Lincolnshire Integrated Voluntary Emergency Service

LIVES Headquarters

Quality Report

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Date of inspection visit: 16 January 2018
Date of publication: 09/03/2018

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

Patient transport services (PTS)	

Summary of findings

Letter from the Chief Inspector of Hospitals

LIVES Headquarters is operated by Lincolnshire Integrated Voluntary Emergency Service and is registered to provide patient transport services, triage and medical advice remotely and the treatment of disease, disorder or injury.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 16 January 2018.

The ambulance service provided patient transport services as well as bespoke first aid and medical cover to public events including treatment on the event site (this is not a regulated activity and is therefore not included in this report). The care and treatment provided when transporting patients between locations and to a hospital is regulated and was the focus of our inspection. 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.

The main service provided by LIVES was patient transport. Where our findings on patient transport services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the patient transport services core service. See patient transport services for main findings.

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.

We found the following areas of good practice:

- Incidents were reported and any learning was shared.
- Comprehensive policies were in place covering all aspects of safe and effective patient care and treatment.
- Medicines management was robust.
- The ambulance and equipment were clean, well maintained and serviced regularly.
- Staff were trained to deliver care and treatment following current clinical guidance and showing compassion and empathy to patients.
- Staff responded to patient's individual needs.
- The organisation was well-led and had a strong patient focussed ethos with processes in place to promote clear clinical governance.
- The senior leadership team were able to respond quickly to any issues in order to improve outcomes for patients.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central), 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?
Patient transport services (PTS)		Lincolnshire Integrated Voluntary Emergency Service (LIVES) Headquarters is registered to provide transport services, triage and medical advice provided remotely and treatment of disease, disorder or injury. The main service was patient transport services. We have not rated this service as we currently do not have the legal duty to rate independent ambulance services. This was a comprehensive inspection, which inspected all elements of the five key questions. We found LIVES was a well-led organisation that provided a safe, effective, caring, and responsive service to patients.

LIVES Headquarters

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

Contents

Background to LIVES Headquarters

LIVES Headquarters is operated by Lincolnshire Integrated Voluntary Emergency Service (LIVES) and is based in Horncastle. LIVES is registered to provide the following regulated activities:

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

A registered manager was in place at the time of our inspection. They had been in post since April 2016.

We last inspected the service in June 2013. There were no compliance actions, requirement notices or enforcement action associated with the service.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 16 January 2018.

LIVES operates a small independent ambulance service in Lincolnshire providing transport for low risk patients requiring conveyance from locations provided by a local community NHS trust. In addition it also conveys patients who require urgent treatment from a local event to the nearest emergency department.

The inspection took place mainly in reference to the patient transport service framework. Where appropriate we reference the urgent and emergency care framework in the report. 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.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector and a specialist advisor with expertise in pre-hospital care. The inspection team was overseen by Simon Brown, Inspection Manager.

Facts and data about LIVES Headquarters

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 LIVES Headquarters in Horncastle, Lincolnshire and inspected the ambulance that LIVES used. We also accompanied the ambulance and its crew on patient transport journeys. We spoke with 15 staff including voluntary responders, a registered

Detailed findings

paramedic, medical practitioners, senior management and a trustee. We spoke with five patients and three staff from the commissioning NHS trust. During our inspection, we reviewed 34 sets of patient records.

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 had been inspected previously in June 2013.

Activity (February 2017 to January 2018)

- In the reporting period February 2017 to 16 January 2018 there were 31 patient transport journeys undertaken.
- In the same reporting period there were two urgent and emergency care patient journeys undertaken.

The provider employed twenty whole time equivalent members of staff. The vast majority of staff gave their services on a voluntary basis including 74 qualified healthcare professionals which included paramedics, nurses, medical technicians and doctors. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (February 2017 to January 2018)

- No never events
- No clinical incidents
- No serious injuries
- No complaints

A local community NHS trust commissioned the patient transport service.

Patient transport services (PTS)

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

We found the following areas of good practice:

- Incidents were reported and any learning was shared.
- Comprehensive policies were in place covering all aspects of safe and effective patient care and treatment.
- Medicines management was robust.
- Ambulance and equipment were clean, well maintained and serviced regularly.
- Staff were trained to deliver good care and treatment following current clinical guidance. They showed compassion, empathy and understanding to patients.
- Staff responded to patient's individual needs.
- The organisation had a strong patient focussed ethos with processes in place to promote robust clinical governance.
- The senior leadership team were able to respond quickly to identified issues in order to improve the service.

Patient transport services (PTS)

Are patient transport services safe?

Incidents

- A comprehensive incident reporting policy was available dated October 2017. Staff were aware of it and knew how to raise concerns, record incidents and near misses and report them both internally and externally. Incident reporting forms were available on the ambulance and at Headquarters (HQ) of LIVES. The form included date, location and full details of the incident with whom and what it involved. In the event of an incident staff told us they would also inform the head of clinical delivery for the organisation.
- All completed incident forms were returned to HQ at the earliest convenience. Although 85 incidents had been raised since 1 March 2017 none had related to conveyance from events or patient transport services (PTS) services. The incidents related to other aspects of the service which were not regulated.
- Lincolnshire Integrated Voluntary Emergency Service (LIVES) had not reported any serious incidents since registration of the service in 2012.The service had not reported any never events in the reporting period February 2017 to January 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- We saw staff reported to the contracting NHS provider and completed an internal incident report when discharge details were inaccurate.
- Any changes to policies and procedures following a safety incident were shared via email and group meetings. 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.
- A comprehensive duty of candour policy was in place with a review date. It referenced joint investigations and learning with any other provider should this be necessary. Staff had an overall understanding of the duty of candour regulation, but due to minimal experience, expected the clinical lead to complete the process.
- Staff described having open and honest conversations and issuing an apology to people who used the service when they were affected by something that went wrong.
- Staff received weekly emails from the clinical director and chief executive officer This included anonymised learning from incidents.

Mandatory training

- Staff received detailed mandatory training through various formats. This included online, classroom and scenario based training.
- Staff described receiving email reminders when training was due to expire. We saw staff offering training across different volunteer groups to ensure staff were trained and classrooms were well utilised.
- If mandatory training lapsed staff were described as being 'off line' and unable to work until all training was up to date.
- For all staff that were 'on line' 100% had completed their mandatory training which was comprehensive in content.. This included basic life support (BLS) and safeguarding adults and children.
- The clinical delivery lead sent emails to all staff to remind them of their training requirements and ensured this was undertaken. Information was kept on a detailed data base and was easily retrievable.
- Once initially trained, voluntary staff were expected to undertake a continuous cycle of training over an 18 month period. Every three years volunteers undertook a three day refresher course to ensure their skills were up to date to enable them to carry on delivering care. Anyone who did not do regular training or their refresher training would be 'stood down' and would not be able to carry on volunteering for LIVES until this was corrected.
- Staff with a C1 driving licence were allowed to drive the ambulance. The C1 driving licence allows people to drive vans up to 7.5 tonnes. Prior to driving, all staff completed a driving assessment before being signed off as competent.
- Over 50 members of staff had qualified to be able to drive on blue lights when conveying patients from an event in an emergency. Training for this was provided either by the healthcare professional's substantive

employer or by an external trainer which LIVES provided. A copy of the certificate was required from a substantive employer before being permitted to drive on blue lights for LIVES.
- Qualified healthcare professionals were required to evidence mandatory training elements from their substantive employer. If this was not provided they would be stood down.

Safeguarding

- LIVES had comprehensive safeguarding policies and processes in place to protect adults and children. This included the systems in place for frontline staff to report safeguarding incidents when they went to or from other providers.
- Commissioners of LIVES services had set the compliance levels of safeguarding training at 80%. LIVES records showed 100% of HCPs had completed level three safeguarding training. We were aware new safeguarding training had been introduced by the provider and at the time of our inspection data for volunteers showed 59% had completed level one of the new training. This was expected to steadily improve and attain 80% compliance over the next two months.
- Levels of safeguarding should comply with the 'Safeguarding Children and Young People: roles and competencies for healthcare staff' intercollegiate document. This states that volunteers across health care settings should be trained to level one.
- The clinical director/registered manager was the lead person for safeguarding within the organisation and was trained to level three.
- We were aware safeguarding training had been a discussion item for the provider. The clinical lead told us the organisation was working towards providing level two for non-healthcare professional volunteers and level four for the safeguarding lead for the organisation. It was acknowledged that the safeguarding lead attended multidisciplinary meetings for children at risk which contributed towards level four training in safeguarding.
- Safeguarding training included specialist elements including PREVENT, which aims to safeguard vulnerable people from being radicalised to support terrorism or becoming terrorists themselves . It also included an element relating to domestic abuse.
- Safeguarding training at level one was included in the induction process for all staff. All healthcare professionals (HCPs), including doctors, nurses and paramedics who volunteered for LIVES were trained to level three for adults and children in their substantive roles; notification of this was required to be submitted to LIVES before they could be used for first aid events.
- Staff were aware of the reporting systems in place and knew how to use them.
- No safeguarding incidents had been reported by staff or volunteers when attending patients being conveyed to hospital from an event or undertaking patient transport services. However, we were informed of occasions when staff had reported such incidents to other providers when this was necessary. This was not when undertaking a regulated activity.

Cleanliness, infection control and hygiene

- The provider had a comprehensive infection prevention and control policy in place which included standard operating procedures (SOPs).
- SOPs within the policy included but were not limited to, bare below the elbow policy for staff giving patient care, management of blood and body fluid spillages and caring for patients who were deemed to be infectious.
- Staff were advised to receive vaccinations for Tuberculosis Rubella (German Measles) Poliomyelitis, Hepatitis B (HBV), Tetanus, Influenza and Hepatitis A (for specific staff groups). The provider monitored compliance wirh this.
- The inside of the ambulance including the cab area was visibly clean and tidy. Re-usable equipment on the vehicle also appeared visibly clean. Clinical wipes were used to decontaminate equipment in-between patients, for example blood pressure cuffs and splints.
- The ambulance contained daily cleaning logs to ensure the vehicle and equipment were appropriately and safely cleaned and ready for use. Signed monthly cleaning logs identified cleaning each day and in between patient transfers.
- The ambulance also contained spill kits for bodily fluids with guidance on their use.
- The ends of shift process included wiping all surfaces and equipment, sweeping and mopping the floor, disposal of clinical and non-clinical waste (usually at a hospital drop off point) and completion of the cleaning log.

Patient transport services (PTS)

- We saw staff disposing of linen appropriately. There was a process in place to remove soiled linen and replace it from the commissioner's own stock during patient transport service journeys.
- Staff had access to reminders on the appropriate cleaning methods and sanitising wipes for each piece of equipment. Staff used sanitising wipes to clean equipment and the trolley between each patient. Trolley, mattress and pillow covers were intact and visibly clean.
- Personal protective equipment was available in the ambulance. This included gloves, masks, aprons and goggles.
- A sharps box was available for use in the ambulance; we found this to be full. After informing the provider this was removed and replaced. Because the use of sharps was small, LIVES had an arrangement with a sharps disposal company to remove the full boxes on request. Full boxes were stored securely at HQ awaiting collection.
- Equipment for initial cleaning of the vehicle (for example a mop and bucket) following an incident at an event was available and stored appropriately on the vehicle. Mop heads were single use only.
- There was a three monthly deep clean schedule in place for the ambulance. If additional deep cleaning was required the vehicle was declared 'off road' until this was completed. LIVES had appropriate arrangements in place to ensure this could take place quickly. A report was completed after each scheduled and additional deep clean. Following discussion with the provider, investigations were going to be made concerning swabbing the vehicle after each deep clean for assurance of the effectiveness of deep cleaning processes.
- Staff on duty for patient transport services on the day of our inspection were smart and tidy in appearance. They adhered to the provider's uniform policy and were seen to be bare below the elbows. Staff were responsible for washing their own uniforms.
- Staff established any specific infection and hygiene risks associated with a patient prior to transfer. If they required advice or support, this was obtained from the commissioning operation centre or LIVES head of clinical delivery.

Environment and equipment

- The headquarters of the building was located in a modern building fit for purpose. Suitable training rooms, office space and storage areas were available with a kitchen and reception area. All areas appeared visibly clean and well maintained. Entrance to the building was through secure fob access doors.
- The provider had one ambulance at the time of our inspection. The vehicle was kept at the headquarters of the organisation where suitable facilities were available for it to be cleaned.
- The provider hired in other ambulances from other independent ambulance providers if needed to ensure they could provide suitable numbers of vehicles when they attended large events for the provision of first aid. However, the provider ensured all personnel, apart from the driver, were LIVES staff.
- Keys for the vehicle were kept in a locked cabinet within HQ with number code access.
- All additional equipment and consumables for the vehicle were kept in a locked store cupboard in HQ.
- A child restraint harness was not available on the vehicle. We raised this with the provider and the day following our inspection we were informed the provider had ordered one for immediate delivery. The vehicle was not able to transport patients over 150Kgs.
- A 'safer ambulance check' was available for staff which provided a clear and robust framework that formalised the daily checks of the ambulance and equipment. These checks were undertaken at the commencement of a shift and prior to any journeys being undertaken: we saw evidence of these. The primary visual vehicle checks included headlights, indicators and lights. Equipment checks included equipment bags, defibrillator and oxygen cylinders. At the end of a shift specific and limited ambulance checks were undertaken which included the defibrillator and oxygen cylinders.
- All electrical equipment in the ambulance had just been serviced and was within date.
- Radios and mobile phones were on charge when we arrived at the provider's headquarters and were fully charged before the vehicle left for the day.
- Cupboards in the vehicle were clearly labelled and stock stacked neatly to enable quick access. Equipment was available for both adults and children including such items as airway adjuncts of various types, for use by different staff up to paramedics/doctors. Airway adjuncts are used to maintain patient's airways so they can breathe.

- There was also a mix of equipment for cannulation. We reviewed sterile supplies; these were stored appropriately and were in date.
- Information was available which evidenced the ambulance was owned by LIVES. It had been taxed and Ministry of Transport (MOT) tested and was within date. Appropriate insurance was in place.
- Any faults identified either before or during a shift which included vehicle defects, missing equipment and vehicle damage were reported to HQ immediately and actions taken to rectify this. All servicing and repairs of the vehicle were undertaken by a local firm, which meant waiting was kept to a minimum.

Medicines

- A comprehensive medicine management policy and a controlled drug policy were in place to provide a framework in which all staff worked to ensure compliance with UK laws on the management of medicines. In addition, to ensure that health care professionals (HCPs) who undertook duties for urgent and emergency care for the provider complied with the regulations of their individual bodies. For example the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC).
- All medicines were obtained safely and stored securely in locked cupboards Any deviation from the acceptable temperature range (15 to 25 degrees centigrade) for drugs to be kept at room temperature was notified to the clinical director and actions taken according to a pharmacist's advice, including destruction of the medicines when necessary.
- Controlled drugs are those controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs (CDs). Examples include morphine for pain relief. The provider had their own private controlled drug register code approved by NHS England. We reviewed the register of those drugs and found the numbers in the secure storage aligned with the number in the CD register.
- CDs were stored securely on the ambulance when being carried by health care professionals (HCPs) who were legally able to administer such drugs under their own private controlled drug prescriber code. The HCPs were personally accountable for administering and recording the CD given.
- The clinical director reviewed use and storage of medicines. Any disposal/destruction of medicines, including CDs, was undertaken by a pharmacist with a clear audit trail.
- Administration of medicines to a patient was recorded on their patient report form with type of medicine, quantity given and signed by the person who gave it with a witness signature.
- Medical gases, namely oxygen and Entonox (50% oxygen and 50% nitrous oxide), used for pain were stored securely on the ambulance. All cylinders were within their expiry date. Additional gas cylinders were kept securely with the keys kept in a combination lock protected safe.

Records

- Patient report forms (PRFs) were of three different types. The first was for use in the case of minor injuries at first aid events. The second was used when transporting patients as part of the patient transport service and the third for treating patients with more complex needs and transporting patients from events. Details in the PRF were dependent upon patient needs but always included patient demographics, observations if this was appropriate and details of the reason for attendance and any allergies.
- We reviewed at random 32 PRFs. They were comprehensive and clearly completed in a legible manner. Documentation included details of the patient handover process and the name of the person caring for/treating the patient. Any drugs administered were also included if appropriate.
- A copy of each PRF was kept securely at LIVES HQ for a period of eight years or until a child who was treated attained the age of 21. Records were then shredded.
- PRFs were audited to ensure key components had been completed and care and treatment had been given appropriately. If issues were identified, staff were spoken with to ensure compliance of appropriate completion and clinical response.

Assessing and responding to patient risk

- Strict criteria were in place for patients able to use the PTS services. If the crew determined the patient was too unwell to move they informed the commissioners of the service as well as their own HQ.
- Staff involved in PTS were suitably skilled to identify and respond appropriately to changing risks to people who

used the service. This included deteriorating health and well being and medical emergencies. In the event of deterioration in a patient's condition, the crew would perform an immediate assessment and any necessary basic life support. If required the crew would call for assistance from the local NHS ambulance trust via a 999 call.

- PTS staff undertaking patient assessments included the use of a modified early warning score (MEWS) and alert, voice, pain, unresponsive (AVPU) scale. The AVPU scale is a system which is taught to healthcare professionals and first aiders to measure and record the patient's level of consciousness. MEWS is a tool to help monitor patients basic physiological readings, for example pulse rate, breathing and blood pressure.
- A flow chart was available for identifying patients who presented with a possible sepsis and initial treatment plan whilst conveying patient to hospital. This included pre-alerting the hospital en route; clear processes were in place when this occured.
- LIVES operated a 24 hour access clinical advice line to members of staff for events. This was manned by healthcare professionals with at least two years of pre-hospital experience. The advice line was also available for on-going conveyance of a patient to an emergency department, and when necessary for patient transport service (PTS) crews. A set of criteria was in place to determine who could give the advice.
- In the event of a serious injury or illness at an event, patients were monitored and treated in the LIVES ambulance whilst arrangements were made for on-going conveyance to a hospital. If the LIVES ambulance was the only one at an event a 999 call was made as the event could not be left without emergency medical support.
- For patients requiring on going conveyance to a local hospital from an event by the LIVES ambulance, patients were assessed and treated appropriately during the journey by suitably qualified staff. This was documented fully on the patient report form (PRF) and included use of the national early warning score for adults (NEWS) or paediatric early warning score for children (PEWS). Observations were on-going during the journey to highlight any deterioration in the patient's condition.
- PTS crews did not transport patients who may have had mental health episodes or conditions or were violent.
- The majority of senior staff working at an event had received training to care for patients living with dementia, patients with mental health conditions or violent patients in their substantive roles. Following discussions with the provider, the clinical director stated that this was an area that will be put forward as an additional training need for all staff.

Staffing

- Twenty whole time equivalent staff were employed at the provider's headquarters. This included the chief executive officer (CEO), clinical director and head of clinical delivery.
- In addition 63 medics volunteered their time to LIVES. Medics are health care professionals (nurses, doctors and paramedics) who have a substantive role generally in the NHS. A further 680 community first responders across Lincolnshire also volunteered their time. As the patient transport service (PTS) was commissioned, staff were offered payment for undertaking this role. However, not all staff accepted payment for their services, instead preferring to donate the money back to LIVES.
- Before the PTS service was commenced the provider asked for expressions of interest from level three or above community first responders. Level three responders are those who have achieved a level three certificate in first response care and are trained to deal with issues such as head injuries, catastrophic bleeding, environmental exposures and recognising and managing major illnesses.
- LIVES did not employ agency staff and only accepted bookings for events which had been risk assessed and resourced with appropriate staffing and skill mix. Two members of staff per day were required to enable the PTS service to function, undertaking a twelve hour duty. Rotas were managed from a pool of 20 volunteers. Because of the number of staff available for the PTS service sickness or absences were not considered a large risk.
- Event resource risk assessments were comprehensive and based on the Health and Safety Executive event safety guide for allocation of appropriate resources. We reviewed one risk assessment and saw it had been risk assessed appropriately and the number of staff required was the number due to attend with the LIVES ambulance.
- Each request to the provider for emergency medical support at an event was risk assessed to ensure appropriate grades and numbers of staff were available

to cover the event safely. If this was not the case the event would be turned down. On occasions of sickness emails would be sent out for appropriate grades of staff to cover the event.
- Events were led by a member of staff who had undertaken specific training relating to this role.

Anticipated resource and capacity risks

- LIVES were able to address any foreseeable resource or capacity risk because of the large workforce they had at their disposal.

Response to major incidents

- As a charity there was no major incident policy or training provided by LIVES. However, if a major incident occurred in Lincolnshire, the medical director informed us they would support the local NHS ambulance trust as much as possible if they were requested to do so.
- If a major incident occurred at an event the provider was attending, staff would take direction from the event organiser, the police and other emergency services.

Are patient transport services effective?

Evidence-based care and treatment

- Patients who required a patient transport service (PTS) were required to meet the criteria laid down by LIVES. This ensured only suitable patients were conveyed and meant staff on the ambulance were able to meet each patient's needs.
- LIVES provided us with copies of comprehensive policies and procedures they had in place which outlined the standard of care and treatment they expected to see when patients were treated by responders and medics. All the policies we reviewed included references to current best practice or pertinent regulations, for example, National Institute for Health and Care Excellence (NICE), the Joint Royal Colleges Ambulance Liaison Committee (JRALC) 2016, Mental Capacity Act 2005 and Misuse of Drugs Act Regulations 2001 and its amendments.
- A paramedic we spoke with told us they followed JRCALC guidelines in line with their registration. They were aware of all LIVES policies and all staff had access to them with any updates from a specific website for LIVES staff.
- Other medics, including nurses and doctors, were required to be aware of their own professional guidance and standards as well as following LIVES policies.

Assessment and planning of care

- For patient transport services, only patients fitting the LIVES criteria were transported to the agreed destination. These included patients medically fit for discharge, haemodynamically stable and who had not received opioid pain relief within the previous hour. Haemodynamically stable means no sign of difficulty with blood circulation – their heart function is normal, they have appropriate blood circulation in their hands and feet, their blood pressure is not low and they have normal urine production. In the event of a patient having additional physical or mental health needs a chaperone was used.
- Protocols on transporting patients were available both electronically and in the ambulance for staff to view.
- The service used information provided to them through the event booking process to plan possible care required for the group of people they may care for.
- During initial assessment of patients requiring care and treatment at an event, patients were asked about medical conditions or allergies to ensure staff had up to date information.We saw that patient report forms identified these questions had been asked and responses documented.

Response times and patient outcomes

- There were no key performance indicators in relation to the patient transport service. However, the commissioning NHS trust was collecting data which may be used in the future. The service was responsive to demand and journeys were booked on the day they were required.
- LIVES had transported two patients to hospital from events in the year January 2017 to December 2017.
- As the LIVES ambulance was always stationed at any large event they were booked for, arrival to patients was prompt and always within three or four minutes.
- Staff were aware the transfer of a patient to a hospital emergency department following an incident was always possible. However this depended upon the severity of the condition of the patient and the urgency of conveyance required. Transfer could be via the LIVES ambulance, the local NHS ambulance trust or an air ambulance. Self-transportation was also sometimes

used. One patient who had had a cardiac arrest had made a full recovery after being treated on scene and conveyed to a local hospital's emergency department by the provider.
- After providing medical support for an event, staff had the opportunity to debrief. This gave staff a chance to discuss the outcomes for patients and share learning.

Competent staff

- A recruitment process, including the taking up of references, followed by formal induction was in place for anybody joining LIVES. This included, but was not limited to, the code of conduct of the organisation, information governance, data protection, infection prevention and control, moving and handling, recognition and relief of pressure damage, communication and documentation.
- Staff who were not healthcare professionals (responders) made up the majority of volunteers in the organisation. Four formalised levels of training were provided dependent upon the volunteer's skill set and desire to improve their knowledge. A national provider of first aid training had based the training it provided on the training given by LIVES to its staff.
- Responders were supported to progress and increase their level of knowledge.
- Annual requalifications for staff were undertaken. If staff failed to undertake this they were unable to volunteer for LIVES. Staff were reminded via email about the dates they were due to requalify.
- Responders mainly worked in groups in local areas within Lincolnshire and were expected to undertake training sessions at least every three months. If they failed to do so the director for clinical delivery contacted them and discussed the issue. Every group had a training lead.
- Staff were required to be at least a level three community responder if they provided the patient transport service (PTS). The staff working on the PTS ambulance were compliant with all essential training.
- PTS staff described receiving meaningful support from peers and managers to address learning needs and service provision.
- All health care professionals volunteering for LIVES were required to provide evidence of formal qualifications and training on joining the service and prior to being able to treat and care for patients. Where revalidation was required to maintain their qualification, staff were asked for evidence of this. If this was not available staff were 'stood down' and could not go on duty until the issue was resolved.
- Volunteers who worked on PTS services did not have appraisals. However they were supported by their area managers, could request meetings with senior managers and could access de-briefs very quickly if they were concerned about an issue.
- Annual appraisals were undertaken for all LIVES medical responders at level four and above. The provider's appraisal compliance target rate was 80% and 100% for doctors. At the time of our inspection the rate was 69% and 100% for doctors. The head of clinical delivery informed us that this was expected to reach 82% by the end of February 2018 and dates had already been planned with staff for these. In the future it was expected the appraisal process would be undertaken via the internet.
- Disclosure and barring service (DBS) certification was undertaken for every member of staff at the beginning of their service and on a three yearly basis thereafter.
- Robust processes were in place if any member of staff did not perform to LIVES standards or an accident occurred in the ambulance. We saw an example of this process.

Coordination with other providers

- Patient transport tasks were allocated each day by the commissioning NHS trust call centre. We saw evidence of staff planning this in partnership between LIVES and the trust.
- We saw evidence of collaborative working with other providers in the provision of transport. The two healthcare providers we spoke with were complimentary on the communication process for booking and liaising with the crew. They described the service as prompt, professional and responsive to patient's needs.
- The PTS crew worked with NHS trusts, care homes and care providers to plan the service and ensure patient safety.

Multi-disciplinary working

- Staff planned journeys with the commissioning NHS trust to ensure patients were discharged at an

appropriate time of day. We observed forward planning and flexibility to ensure patients arrived at their destination at a time suitable for all concerned. Journeys were co-ordinated with the head office.
- Staff attending events with on-going patient conveyance to a hospital worked closely with the local ambulance NHS trust as well as emergency departments.

Access to information

- For patient transport services (PTS) staff received minimal information about the patient prior to transfer. Staff described the information as suitable and further updates concerning the patient were available if required. We observed staff escalating concerns when the information received was not accurate.
- For PTS, patients moving between teams and services, including referral, discharge and transfer were given discharge or transfer letters containing relevant information. This supported on-going care in a timely way.
- In the event of a patient having any special requirements staff made a decision on a case-by-case basis on the suitability for transfer and would decline the transfer if they thought it appropriate and after discussions with the provider..
- Staff had an awareness of 'do not attempt cardio-pulmonary resuscitation' orders. We discussed this issue with the provider in relation to the PTS service provision and an addition was going to be made to the standard operating procedure to ensure staff felt empowered to ask about this prior to transfer of patients.
- Due to the nature of events covered by LIVES, there was a reliance on patients, friends or relatives to inform them of any medical conditions or allergies at point of treatment.
- A satellite navigation system was in place and in use on the ambulance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a comprehensive consent and mental capacity policy in place. Staff had an understanding of the relevant consent and decision making requirements of legislation and guidance including the Mental Capacity Act 2005 and the Children's Act 2004.
- In the event of patients not being able to give consent to travel in the ambulance for patient transfers, staff informed us a chaperone would be required. LIVES staff were not responsible for assessing an individual's capacity or making best interest assessments. A lack of consent would result in not transporting without a chaperone.
- Staff were able to decide whether or not a patient was able to consent to treatment and document this on the patient report form used on transfer from an event.
- Restraint processes, other than legally required seat belts, were not used within the ambulance.

Are patient transport services caring?

Compassionate care

- We saw evidence of staff respecting patient's personal, cultural and social needs. Staff were polite and respectful of people's homes when returning patients to them.
- We observed the ambulance crew ensuring patients were covered when on trollies and carry chairs and the vehicle door was closed to ensure dignity was maintained as far as possible during transporting.
- Staff took time to interact with patients and those close to them in a respectful manner. Time was taken to contact a relative to ensure a patient was not at home alone.
- During our inspection a patient told us the service was 'absolutely wonderful' because staff had had the time to care and made them feel they were special.
- Staff established patient's needs from both the staff handing over care and the patient themselves.
- When transporting more than one patient, staff gained patient consent and supported a three way respectful interaction during the journey. If patients were not confident to travel with others, alternative arrangements were made.
- We saw the crew stopping the vehicle to support repositioning of a patient who was in physical pain. Staff were compassionate and patient when supporting them to move to a more comfortable position.
- Telephone calls to the ambulance crew, including personal details and referrals, were not taken in front of other patients.

Understanding and involvement of patients and those close to them

Patient transport services (PTS)

- Patient transport crew explained carefully to the patient the plans for transporting them prior to gaining consent. There was a clear explanation given as to what LIVES was and the role of the organisation.
- Staff had an understanding of the needs of patients, including those in need of additional support to help them understand.
- Patient report forms (PRFs) indicated patients were involved in decisions about their care and treatment.
- As a charitable organisation, patient feedback and perception were key to the organisation's reputation. Feedback received during the inspection was overwhelmingly positive.

Emotional support

- Staff were able to describe difficult situations they encountered such as transporting patients in the last few days of their life. Their emotional understanding was indicative of staff's ability to support both patients and families during a stressful time.
- We saw staff sitting with a patient, supplying refreshments and contacting family to ensure they were fully supported.
- Due to the nature of the LIVES organisation, staff felt they were not under the same pressures as their peers in other patient transport organisations. They could spend additional time providing extended emotional support when this was required.

Are patient transport services responsive to people's needs?

Service planning and delivery to meet the needs of local people

- The patient transport service (PTS) was a new and evolving service. Discussions were being held regularly with the commissioners to discuss the possible future of the service.
- Events and possible conveyancing of patients to a local hospital were planned when the provider was asked to provide first aid cover. We were informed LIVES only accepted bookings for events for which they could guarantee the correct resources to meet the brief provided by the organiser and following their own risk assessment process.

Meeting people's individual needs

- The service followed strict criteria for transporting patients. This took into account the needs of individuals.
- Staff supplied pillows and blankets to improve patient comfort and ensure patient dignity during transportation.
- The ambulance was not designed for conveying patients in their own chairs. If a patient could not transfer onto the ambulance chair or stretcher they were not transported by LIVES.
- In the event of conveying a patient living with dementia or a learning disability, the ambulance had room for a chaperone if required. This meant the patient was less anxious.
- Staff carried bottles of water on the vehicle for patients if this was required. We saw staff prompting a patient to take a sandwich from the ward so they had sufficient food for the journey.
- LIVES health care professionals and responders had a variety of healthcare experience enabling them to care for patients with a wide range of individual needs.
- The provider did not provide explicit training in caring for people with for example a dementia, learning disability or mental health conditions although communication was covered as part of the induction process for all staff. The provider acknowledged this and informed us after the inspection that plans were being put in place to address the deficit.
- The importance of communication was taught in staff induction. Every bag of equipment held by staff had language cards which helped with communicating with patients whose first language was not English. These included Polish, Lithuanian and Russian.
- Information cards regarding the service were given to patients where appropriate to improve their understanding of LIVES.

Access and flow

- Patient transport services were provided on an ad hoc basis. Journeys were planned on the day required, following requests from the duty desk of the commissioning NHS trust.
- Patient report forms (PRFs) included timings of attendance, treatment, discharge or transfer. Commissioners of patient transport services were collecting these but had not audited them so far.

Patient transport services (PTS)

- The event service provided by LIVES was based on the site of the event with staff able to respond within minutes of being required.

Learning from complaints and concerns

- A comprehensive complaints policy was in place dated April 2017 which staff were aware of. The policy set out clear guidance and responsibilities for staff with specific timescales for complaints to be resolved. This was usually 25 days but could be extended if complaints were more complex. The process involved incident definitions and a risk management matrix to determine the consequence of the incident and likelihood of it occurring again. The outcome determined how the risk would be managed in the organisation with priorities assigned for any remedial action required.
- The chief executive would always be made aware of any complaint taking more than five days to resolve and on completion would be discussed at the next clinical governance meeting. All necessary action was taken and appropriate lessons learned and shared.
- There had been no complaints raised in the twelve months prior to our inspection from patients or their relatives in relation to patient transport services or those being conveyed to hospital from an event. However we were informed about complaint investigations from the delivery of first aid services (which is not regulated) and found the process had been robust and actions taken when necessary.
- A joint investigation would be undertaken by the provider with the commissioner of patient transport service if and when this was appropriate. Any learning from these would be cascaded to all staff.
- Positive comments and emails about the LIVES provision of services had been received from event organisers.

Are patient transport services well-led?

Leadership of service

- The management structure of the organisation was fairly flat to reflect its size. Trustees and senior management had the experience, knowledge, integrity and skills to lead the service which included health care professionals who still practised in their field. This ensured policies and procedures reflected current clinical practice of staff. The chief executive officer (CEO) was also the registered manager with CQC for both regulated activities that LIVES undertook.
- The trustees of the LIVES charity were ultimately accountable for the organisation's charitable objectives. At the time of our inspection there were seven trustees in place with lengths of service ranging from three years to 30 years and having a range of experience. The chair was rotated to give all trustees the opportunity to fulfil the role and strengthen the relationship between the trustees and the CEO.
- We reviewed information kept by the organisation to ensure trustees were fit and proper persons to carry out this role. We found not all the information for each trustee was present, for example a photograph, two references and an enhanced Disclosure and Barring Service (DBS) certificate. We raised this with the CEO who immediately took steps to rectify this. Following our inspection a fit and proper policy was put in place and we were notified on 31 January 2018 that all required documents and appropriate checks of various registers were in place for each trustee to ensure they met the requirements of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3): fit and proper person requirements.
- The leadership team understood their role and responsibilities in ensuring patient care was safe and effective. The CEO and clinical director for the service were able to express their passion for delivering excellent care by training and supporting their staff team to do that.
- The leadership team was visible and approachable; this was evidenced by comments from staff we spoke with who told us they knew they could contact any of the leadership team if they wished to discuss anything or required support. Although the majority of the workforce was spread across Lincolnshire, weekly informative updates were sent to all employees via email from either the Chief Executive Officer or the Clinical Director.
- An annual general meeting was held and regular events were planned in various locations across Lincolnshire for the leadership team to meet with as many of the workforce as possible.

Patient transport services (PTS)

- Responsibility for clinical delivery was undertaken by a senior nurse who was also responsible for ensuring all training delivered to staff was of a high quality and followed current clinical guidance.

Vision and strategy for this core service

- LIVES expressed a vision to ensure their service remained Lincolnshire focussed in the future, building on their existing skills and aligned with their current work stream. This would mean ensuring their staff were informed, well trained and provided a high quality caring service to the people they served. They also expressed their desire for future regulation of both event and community responder first aid and emergency care provision to ensure safe services for members of the public.
- As a charity, trustees and senior management expressed a sincere desire to ensure business opportunities did not outweigh the importance of clinical quality in the delivery of their services. There would be a focussed reflection at the end of March 2018 to review the past year and provide an opportunity to look forward and draw up a strategic plan for the next 12 months. Quality and safety would be at the forefront of all plans.
- Trustees and the senior management team were extremely aware of the pressures and risks associated with the current provision of patient transport services to a local NHS community trust. These will be reviewed at the end of the current contract.
- Staff we spoke with were focussed on providing a quality service that made a difference and saved lives. Because of the regular contact from senior management to all staff across the county, staff were aware of the organisation's focus.

Governance, risk management and quality measurement

- Governance, risk management systems and processes within the organisation were robust. Lines of accountability were clear and risks were managed effectively. Policies covering all aspects of the organisation were reviewed three yearly or more often if this was required. We saw one newly implemented policy which had been reviewed very regularly as a result of feedback from staff.
- LIVES had a formal governance framework in place to monitor the quality of care and treatment. This was supported by regular minuted meetings reflecting discussions and any actions required, for example clinical governance meetings which were held bi-monthly.
- Staff were clear about their roles and responsibilities in relation to patient transport services and conveying patients to hospital from events. They informed us who they would refer to if they needed advice to resolve an issue and felt well supported by the system in place.
- A comprehensive risk register was in place which was last reviewed on 7 December 2017 with a red, amber, green (RAG) rating in place for each item. Actions to mitigate any risk had been clearly identified. Levels of risk for each item were in place which was supported by the risk management strategy and policy. Levels of risk had been based on the National Patient Safety Agency (NPSA) and included clinical governance which was rated as green (low). Lone working had been identified as red (high) because of event coverage. Plans were in place to mitigate the risk by ensuring staff were aware of the risk during their training as part of their essential/ mandatory education.
- Formal and informal methods were used to ensure staff were following correct processes and procedures. For example ad hoc visits by senior clinical members of staff to an event to review clinical procedures. These were undertaken to ensure patients were safe and ready for conveyance when appropriate.
- Patient report forms were audited on a monthly basis for completion, clarity of documentation and clinical practice delivery. Any issues identified were investigated with the person completing the PRF to improve the service.

Culture within the service

- The culture of the organisation was one of inclusiveness, caring and openness. Caring for patients was seen as a priority. From reviewing a sample of the weekly updates we saw they encouraged openness by sharing and we were able to see this during our inspection.
- Patient transport staff were aware of who the leadership team were and their individual responsibilities. They described supporting each other and working hard to ensure the service was covered through collaborative working.
- LIVES had a comprehensive duty of candour policy which was reviewed in December 2017 and reflected the

guidance as laid out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All staff were required to be familiar with the policy and be open and say 'sorry' if things went wrong. The policy stressed the importance of identifying and reporting safety incidents and adopting openness and transparency. The organisation had no duty of candour incidents in the previous twelve months.

- Any reaction to a reported incident was undertaken in a neutral and supportive way. We were given an example of how this had occurred.
- Opportunity was given for all parties to be listened to if there was any conflict amongst individual staff or teams. Where possible compromise was agreed and if necessary a trustee and/or a member of human resources was involved.
- The leadership team used an electronic system to enable staff to vote on particular issues that could cause concern before any decision was made. This ensured all staff were able to be involved in the decision making process.

Public and staff engagement (local and service level if this is the main core service)

- Other than staff at headquarters all staff gave their services voluntarily. Staff were contacted frequently via online surveys around specific topics rather than on an annual basis. The chief executive officer informed us that better response rates were recorded using this method with the online tool able to keep track of the responses. There had been five issued in the last twelve months including request for information on the support available for health care professionals and support available for younger volunteers.
- The organisation was aware of the importance of engaging staff and had reviewed the results and responded appropriately. For example talks were on-going concerning how the organisation could support younger members of staff to develop leadership skills and experience, and how they could create a more formal mentoring structure for those who were interested in pursuing health care careers.
- An on-going survey was in place to ensure any member of staff resigning was able to give their feedback and comments on the organisation and changes made where appropriate.
- During our inspection a patient told us the service was 'absolutely wonderful' because staff had had the time to care and made them feel they were special.
- Feedback cards were available in the ambulance for staff to distribute to patients receiving a transport service. To date none had been returned.
- Local staff groups across Lincolnshire held monthly meetings to discuss issues and undertake training sessions. This ensured their practice was up to date and reflected current guidance and where appropriate updated policies.
- Regular meetings were held with commissioners of LIVES services to discuss any issues that had arisen and put actions in place to resolve them if appropriate. At the time of our inspection the PTS service had been well received and no negative comments had been made.
- Feedback from organisers of events was always sought regarding delivery of the service provided. We reviewed four and found all comments to be extremely positive especially upon the professionalism and manners of the staff.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- As LIVES was a charity, sustainability of the service was a high priority.
- The trustees and senior leadership team recognised that in order to improve the service they delivered LIVES needed to continually innovate service delivery in the medium and longer term. This would develop services to support both the health and emergency provision across Lincolnshire. The patient transport service had evolved from this.
- The organisation was not limited in their ability to innovate as long as their core function was not compromised. Quality of patient care and safety was always a priority and the leadership team was focussed on this.

Outstanding practice and areas for improvement

Outstanding practice

LIVES leadership demonstrated an open and inclusive approach to all its staff which ensured they felt supported at all times.

The leadership team regularly sought staff opinion before making decisions.

A clinical leader was on call 24 hours a day to support and advise staff.