Lincolnshire Integrated Voluntary Emergency Service

LIVES Headquarters

Inspection report

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Date of inspection visit: 14 November 2023
Date of publication: 22/01/2024

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated this location as requires improvement because:

- Staff records were not always easy to find or review because of the multiple systems that were in use. The service had high turnover and sickness rates.
- The service did not submit any required safeguarding notifications to us.
- There was no staff infection, prevention control audits in place.
- Staff did not always complete and update risk assessments for each patient.
- The service did not have an in date home office licence for controlled drugs at the time of our inspection.
- The service also did not provide any training for staff in restraint. The service did not mandate that staff completed training in recognising or responding to patients with mental health needs.
- Clinical audits were not always completed consistently. Staff did not consistently record patients pain scores.
- Work was not always allocated in a timely way by the ambulance trust.
- There had been a recent period of instability in leaders in the service. Not all staff felt respected, supported, and valued. At the time of our inspection the service did not have a business continuity policy that reflected current service provision.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The design, maintenance and use of facilities, premises, vehicles, and equipment kept people safe. Staff managed clinical waste well.
- The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence-based practice. The service monitored and met agreed response times so that they could facilitate good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. All those responsible for delivering care worked together as a team to benefit patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Requires Improvement 	We rated this service as requires improvement because it required improvement in safe, effective, and well led. However, it was good for caring and responsive.

Summary of findings

Contents

Summary of this inspection

Background to LIVES Headquarters

LIVES Headquarters provides medical response to emergency situations across Lincolnshire. All work (including community first responders work) was allocated through the local NHS ambulance service.

The service had two commissioned services. The Community Emergency Medicine Services (CEMS) which operates from 8 am to 8 pm daily, brings the Emergency Department to the patient, meaning patients could be treated at scene and often avoided having to go to hospital. They also had a Falls Response Unit which responded to calls from 6am to 2am daily. This service provided assistance for falls and related injuries, delivered by non-qualified health care professionals.

The service also had a team of voluntary staff (approximately 300 at the time of our inspection) who made up the community first responders: Levels 1-4. They logged on from their own homes and travelled in their own vehicles to patients allocated by the local NHS ambulance service. They were split based on their geographical locations into 24 districts across the county. There were different grades (also referred to as levels) of these staff. This went from level 1 who were in their mentorship period and had some competencies signed off. Level 2 who were community first responders. Level 3 who had a year's experience and had completed FREC level 3. Level 4 who were FREC level 4 trained. Levels 5-8 were medical first responders. Within the community first responders there was also MEDIC50 team which comprised a more highly skilled volunteers who had critical care skills. This team covered evenings and was looking to expand to cover weekend daytimes. These have a dedicated vehicle and would only respond in a team of two. Work was allocated based on individual skills and competencies.

From November 2022 to October 2023 the service had 4017 CEMS call outs, 2255 Falls team call outs, 704 medical responder call outs and 4140 community first responder call outs.

The service is registered with CQC for the regulated activity transport services, triage and medical advice provided remotely, and treatment of disease, disorder, or injury. The service is also registered for the regulated activity of diagnostic and screening procedures and surgical procedures.

The service has a Registered Manager who has worked at the service since 2016.

We previously inspected the service in 2018, however we did not rate the service at this time. We carried out an unannounced inspection on 14 November 2023, using our comprehensive inspection methodology. We inspected this service after receiving information of concern.

How we carried out this inspection

We carried out an unannounced comprehensive inspection on 14 November 2023. The inspection was carried out by 2 CQC Inspectors and 2 specialist advisors. The inspection was overseen by a CQC Operations Manager and a Deputy Director of Operations.

During the inspection we spoke with 18 members of staff. We inspected 2 vehicles. We inspected the registered location building. We reviewed 9 staff files and incidents and complaints investigations and reports. We also observed one episode of patient care.

Summary of this inspection

Following the inspection, we spoke with 16 members of staff. We reviewed 10 patient record forms. We reviewed feedback from 10 patients/their families or professionals who had been present when LIVES staff had seen patients. We also spoke with system partners and the services commissioner.

The service was previously inspected in January 2018 but not rated. This inspection was planned because CQC had received information of concerns.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure it audits staff's adherence to its infection control policies and procedures. (Regulation 17 - Good governance)
- The service must ensure staff fully complete risk assessments, including NEWS scores, for patients and update them where required. (Regulation 17 - Good governance)
- The service must ensure guidelines from staff on restraint of patients are clear and consistently followed. If this includes restraining patients, then staff must be trained to do this safely. (Regulation 18 - Staffing)
- The service must ensure they have enough staff to safely deliver services. (Regulation 18 - Staffing)
- The service must ensure that patient record audits are consistently completed. (Regulation 17 - Good governance)
- The service must ensure that it continues to work on the culture of the organisation so that staff feel able to raise concerns. (Regulation 17 - Good governance)

Action the service SHOULD take to improve:

- The service should consider offering mental health awareness training for all of their staff.
- The service should ensure it continues to work to streamline staff records to ensure they are easy to find and fully complete.
- The service should continue to work with the local NHS ambulance trust to increase patients access to the service.
- The service should ensure that routes for speaking up for staff are continued to be strengthened.
- The service should ensure that business continuity policies are up to date and available for staff.
- The service should ensure that they have an up-to-date home office licence for controlled drugs.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Emergency and urgent care

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key to all staff and made sure everyone completed it. However, the service did not mandate that staff completed training in recognising or responding to patients with mental health needs.

All staff received and kept up-to-date with their provided mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Training completed was a mixture of online and face to face. All staff regardless of role were offered basic life support training which linked to the organisations objective of growing the impact of the organisation by spreading lifesaving skills across the county.

Clinical staff completed training on recognising and responding to patients with learning disabilities, autism, and dementia. The service did not mandate that staff completed training on recognising and responding to patients with mental health needs or restraint training due to the fact that their staff were not primary responders to mental health emergencies.

Managers monitored mandatory training and alerted staff when they needed to update their training. If staff did not complete their mandatory training, then they were not permitted to work for LIVES until they had completed it.

Prior to working for the service, staff's qualifications to drive under blue light conditions was checked. For those that held the qualification prior to starting this was recorded on their file and if required their own vehicles would be fitted with blue lights by LIVES. This was checked on an ongoing basis and if anyone had the qualification for five years then they would be required to complete an additional qualification to test their ongoing safety. If staff were required to drive under blue light conditions but did not have the qualification prior to starting with the service, then they would be supported to complete this qualification by LIVES.

Safeguarding

Requires Improvement

Emergency and urgent care

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, staff records were not always easy to find or review. The service did not submit any required safeguarding notifications to CQC.

Staff received training specific for their role on how to recognise and report abuse. The service had 2 safeguarding leads, trained to level 4 in safeguarding, and staff were aware of who they were and how to contact them if they had any queries. Depending on their role staff were offered different levels of safeguarding training. At the time of our inspection, for those staff eligible for Safeguarding adults and children level 1 there was a compliance rate of 95.65%. For those eligible for level 2 training there was 100% compliance. For those eligible for level 3 training there was 97% who had completed Safeguarding adults' level 3 training and 100% who had completed Safeguarding children level 3 training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The provider had a safeguarding adult policy and a separate safeguarding children policy both of which were in date, version controlled and had a review date. The policy outlined key responsibilities, different types of harm, procedures for reporting and useful contact numbers.

Recruitment and staff background checks were done in collaboration with an external HR company. Prior to starting working for the service staff were required to submit a number of different documents and have a Disclosure and Barring Service (DBS) check completed. Once these checks had been completed the hiring manager would sign off the checks to say they were safe to commence work. Over the years the organisation had used a number of different storage methods for these checks, both paper and online. This meant that during the inspection when we reviewed staff files it was often difficult for staff to find the required information across the different systems.

Of the 9 staff files we reviewed the service were able to provide the required information whilst we were on site, however it did require a lot of input from staff. Following the inspection, the managers of the service provided us with assurance that whilst some of the records were not easy to find that they were available and were doing work to ensure that all staff files were fully up to date on the new system.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of where they had made safeguarding referrals to ensure that people were kept safe either in their own homes or in another healthcare setting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The community first responder team would complete a Microsoft form which would be sent to the NHS ambulance trust for them to make the referral. The commissioned services' forms would be uploaded to a dashboard and the referral to the local authority safeguarding team would be made by the LIVES team.

From July 2023 to November 2023 the service had made 10 safeguarding referrals to the Local Authority from the Falls/ CEMS teams. However, the service had not submitted any safeguarding notifications to the CQC.

The service held a fortnightly safeguarding review group which reviewed all safeguarding concerns and if there were any outstanding actions to be completed. This group fed information into the board level clinical governance committee which was chaired by a trustee.

Requires Improvement

Emergency and urgent care

Cleanliness, infection control and hygiene

There were no infection prevention control audits in place. However, the service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment, vehicles, and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

At the time of our inspection, 97% of eligible staff had completed infection, prevention control level 1 training.

There were no infection prevention control audits in place at the time of our inspection. This was a risk because it meant that the service had no oversight of staff working out in the community if they were following the correct infection prevention control measures when they were treating patients.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. None of the services or volunteers vehicles were used to transport patients. All vehicles were wiped down at the end of each shift. The service contracted an external company to come in to do swabs of vehicles to check for cleanliness levels and to do deep cleans.

We inspected two response vehicles during our inspection. Both vehicles inspected appeared visibly clean and we saw evidence that daily vehicle and equipment cleanliness checks had been completed by the crew on shift for each vehicle inspected. All the vehicles we inspected had supplies of hand gel, decontamination wipes and personal protective equipment (PPE). The vehicles inspected had sharps containers and clinical waste bags.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff could access additional PPE from the stores at head office or from smaller stores out in the community which were managed by dedicated store manager or by regional coordinators depending on the size of the area. This meant that staff and volunteers did not have long journeys to be able to replenish their stocks. Staff told us they could access replacement PPE whenever it was needed.

The provider had an infection, prevention and control policy which was in date, version controlled and had a review date. The policy highlighted key responsibilities, standard procedures and what to do in different situations.

There was a clinical advice line and a duty manager line available 24 hours a day 7 days a week where staff could seek advice on infection control issues. Staff also had access to over the phone clinical support from the NHS ambulance service if they had any concerns.

Environment and equipment

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

The service had seven vehicles for use, none of these vehicles would be used to transport patients. Managers we spoke with could explain the process surrounding vehicle servicing and repair which was through local garages or car

dealerships. If a vehicle was taken off the road, then other vehicles in the fleet would be used if available or a hire vehicle used. Volunteers drove to patients in their own cars. The service monitored and recorded that they had suitable insurance, tax and Ministry of Transport Test (MOT's) for their cars. The services vehicles had access to breakdown cover. All keys for vehicles were stored in safes in the services head office with only relevant staff who had access.

The service had enough suitable equipment to help them to safely care for patients. Consumables were restocked at the end of shifts and if this was not completed (for example due to a shift overrunning) then this was communicated with the next team. All clinical bags were tagged to say that they had been restocked.

The service provided staff and volunteers with equipment that they were competent to use and that would be required during their role.

Staff reported that there were enough vehicles for the service to meet the demands of the local population.

Staff carried out daily safety checks of specialist equipment. How to carry out daily visual checks of equipment and to check if the equipment was working was included in staff's induction programme. If any equipment was not working this would be flagged to managers through an online reporting system and if required replacement equipment would be sought.

All medical devices were checked by an external company on a yearly basis. All lifting equipment was checked by an external company on a six - monthly basis.

Staff disposed of clinical waste safely. For the community first responders they handed any clinical waste to the attending ambulance crew who would then be responsible of disposing of it following their guidance. For the Falls and CEMS teams they had access to different types of clinical waste bags and disposed of these in dedicated bins at the head office following their shift.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. The service also did not provide any training for staff in restraint. However, there were clear processes for the escalation of deteriorating patients.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. There were clear processes for the escalation of deteriorating patients. All staff had access to remote medical advice from within LIVES. Community first responders were able to contact the LIVES clinical support line, or they could request further support from the NHS ambulance service. They could also request additional resources through the operations centre, for example if a community first responder required an ambulance for a patient. LIVES also had an on-call clinical advice line that staff could ring if they had any specific questions. All staff had clearly defined scopes of practice within which they worked and if patients required additional interventions, then would seek people with additional skills.

Staff completed risk assessments for each patient on attendance. We reviewed 10 patient records, all patients had at least one set of observations recorded. However, 7 out of the 10 records did not have a National Early Warning Score (NEWS score) calculated. The patient record forms did not have a specific space for recording a check of patients' allergies, there was only a free text 'incident summary' box where this could be recorded. We saw that in 4 out of the 10 records we reviewed there was no documented review of the patient's allergies.

Staff knew about and dealt with any specific risk issues. As far as possible this would be handed over from the NHS ambulance trust who allocated work to staff.

The service had 24-hour access to mental health liaison and specialist mental health support. (if staff were concerned about a patient's mental health). If staff were concerned about a patients' mental health then they would inform the ambulance trust who allocated their work who would send an appropriate team.

Staff shared key information to keep patients safe when handing over their care to others. All patients attended had a patient record form completed. These were kept by LIVES and a copy was left for the patient or handed over to the service receiving the patient.

Shift changes and handovers included all necessary key information to keep patients safe.

Risk assessments were completed by the NHS ambulance service for risks associated with lone working within the community first responder team. Any indication of an unsafe situation would mean that staff in these teams were not sent to those patients. The operations centre were aware of when people were lone working and would check in with them if they hadn't heard from them within expected timescales. The local system was tendering for a lone worker tracking system and the service and when this was decided upon LIVES intended to use this.

Three staff members told us how they had to restrain patients. The service did not provide any restraint training for staff. Other staff told us how they would leave a situation and call the police if there was an escalation of behaviours by service users.

Staffing

The service had high turnover and sickness rates. However, the service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had high turnover rates. From November 2022 to October 2023, the service had 15 (8.8 WTE) members of staff leave the head office. 6 of these were employees whose contracts were ended due to a lack of shifts undertaken in their specific role. There had also been 7 (3.975 WTE) leavers from the CEMS team. Staff told us they were concerned about patient safety in the CEMS team due to staff leaving or being off sick.

The service had high sickness rates in the CEMS team. From November 2022 to October 2023 the head office team had an average sickness rate of 2.08%, the falls team had an average sickness rate of 4.82% and the CEMS team had an average sickness rate of 8.93%. From May 2023 the sickness rates per month for the CEMS team were always over 10.5%.

Staff told us that they didn't feel that there was enough staff in the head office doing business support work to be able to carry out all the requirements of the service. We were told of plans to review certain areas of the head office structures to ensure that there was the right staff in place.

However, the service had reducing vacancy rates. The service had recently recruited four new members of staff for the falls team and were in the recruitment process for the CEMS team at the time of our inspection.

The service did not use any agency staff.

Requires Improvement

Emergency and urgent care

The service monitored volunteers to make sure they were not working excessive hours and gave guidance on what was appropriate. All volunteers had to commit to a minimum of 16 hours a month (averaged over 3 months). This was to be logged onto the system to receive calls. However, we were told that being logged onto the system did not necessarily mean that you had any work allocated and on average people would be logged onto the system for 17.5 hours before they were allocated work.

The Management team within the service were conscious when conducting recruitment campaigns to ensure that not too many staff were recruited in one team at one time to ensure that the team could offer support with the training and onboarding into the service.

Previously for volunteers there had been an open ongoing recruitment in place. However, the services recruitment was now planned to be conducted in a more targeted way to target areas that required more volunteers.

Managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service.

Records

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

Patient notes were not always fully completed, however, all staff could access them easily. Patient record forms were on paper. The service had plans to move to electronic patient records in the next financial year. During inspection we reviewed 10 patient record forms (PRF`s) which were mostly completed correctly, were legible, and included information in relation to medicines, pain relief, consent, and mental capacity as well as handover information. However, not all of the records had NEWS scores calculated, had allergies recorded or had pain scores completed.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff gave all receiving clinicians a copy of the patients record form and this would be left with the patient or their family member in their home if they were discharged.

Records were stored securely. Staff working in the community had tamper proof document envelopes in which they placed their patient record forms in for storage and then these were posted, or hand delivered to the head office a minimum of once a month. These were then scanned onto a computer system with the hard copies saved in storage at head office.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the service did not have an in date home office licence for controlled drugs at the time of our inspection.

Staff followed systems and processes to prescribe and administer medicines safely.

The service had a medicines management policy. This included information on different responsibilities, prescribing, management of medicines and processes to follow.

Medicines were administered under the appropriate authority. Patient group directions (PGDs) were in place for some medicines. There was a process in place to ensure that the PGDs were in date and the provider knew when reviews were needed.

At the time of our inspection the home office licence for the controlled drugs was out of date. The service had applied for an updated licence but due to national delays in the system had not yet been reviewed or updated.

Staff completed medicines records accurately and kept them up-to-date. In four of the four patient records we reviewed we saw that medicines were prescribed and recorded appropriately.

The service completed randomised medicines audits, to check individual staff members management of their medicines, 4 individuals were completed a month. The company vehicles and their stock was also audited every month to ensure these medicines were stored and correct.

Staff stored and managed all medicines and prescribing documents safely. During inspection we reviewed storage of medical gases at the head office. Medical gases were stored safely in accordance with national guidance under the Health and Safety at Work Act 1974 and Health Technical Memorandum (HTMO2) guidelines. Staff we spoke with told us there was always enough full medical gas cylinders to exchange for empty ones. We also reviewed documentation and the storage of medicines in the head office. These were stored securely with all required documentation completed. When staff were out in the community, controlled drugs were stored in sealed and coded bags to ensure that they couldn't be tampered with.

Staff learned from safety alerts and incidents to improve practice. These would be shared with staff through the services bulletin system which was available for all staff through their mobile phones.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. There was a QR code on the back of all staff's identification badges which had a link to allow staff to report incidents. Staff were aware of this, and managers told us that since its introduction they had seen an increase in the number of incidents reported.

The service had 427 incidents reported in the year prior to our inspection. The main themes from the incidents report were in relation to the ambulance services dispatch service, equipment, and the fleet. There was also the option to record excellent practice for which staff felt needed to be shared with others and these were reported 22 times in the year prior to our inspection.

From November 2022 to November 2023 there had been 122 learning events raised in relation to the NHS dispatch centre. Of these 14 related to there being no one to cover the desk and 20 were due to no one answering the phone.

The service had no never events or serious incidents in the last year.

Staff reported incidents clearly and in line with the providers policy.

Requires Improvement

Emergency and urgent care

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. We saw evidence that this had been completed following an investigation we reviewed. The service had a duty of candour policy which was in date at the time of our inspection, it detailed key definitions, key responsibilities, and processes to follow.

Staff received feedback from investigation of incidents. This was done on either an individual basis or through the company's online bulletin system.

Staff met to discuss the feedback and look at improvements to patient care. The service had a fortnightly learning from events group which managers attended. They reviewed all medium and high scored incidents to look for themes and trends and to ensure they were being handled in line with company policy.

There was evidence that changes had been made as a result of feedback. Where required the service hired external experts to investigate incidents or to help with learning. Staff could provide examples of where learning had been taken as a result of incidents. For example, the service had seen a rise in the number of controlled drugs vials being broken on vehicles. They had explored this and discovered the pouches that they were stored in were not the correct size and so had ordered some replacements.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There was an online template for staff to fill in which guided the investigation for staff. If relevant, the service would share incidents reported with the local ambulance service for them to investigate through their incident reporting system.

Managers debriefed and supported staff after any incident. There was a process for debrief following serious or challenging incidents. This involved having an immediate debrief to check on staff and then having a full debrief at a later point. Senior leaders also supported staff in a more informal way after any challenging incidents.

Is the service effective?

Requires Improvement

We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had a bulletin system where updates were shared. These were colour coded depending on urgency. Red bulletins would be sent out that day. Amber bulletins were collated and sent out weekly and green was collated and sent out monthly. All staff had access to these bulletins and policies through an online portal accessible through their mobile phones.

We saw evidence staff had access to all company policies and protocols online, through a computer system which was accessible on staffs' mobile phones. Staff could use IT systems to access forms, such as incident forms and safeguarding forms.

For the more qualified staff members there was a forum to share anonymised job notes to allow them to reflect on where things had gone well, or things could be improved. This was also reviewed by other clinicians for their input. This could be done by individuals when they felt they had a difficult case, but certain situations would automatically trigger a review such as anaesthetising a patient.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

We reviewed the service specifications for the Falls and CEMS teams. This fully outlined what services were to be provided, staffing arrangements, data collected and the governance of the services.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. However, staff did not consistently record patients pain scores.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff could describe how they would assess a patient's pain using pain scores, pictorial pain scores and to speak with family members or carers. They explained how they would check if the pain was a new pain or a chronic pain and obtain a full history of the patient.

Patients received pain relief soon after it was identified they needed it or they requested it.

Staff prescribed, administered, and recorded pain relief accurately.

We saw mostly evidence of pain being identified and pain relief medication being recorded on the patient record forms which were reviewed following the inspection. However, in 2 out of the 10 records we looked at there was no documented evidence of a pain score.

Response times

The service monitored, and met agreed response times so that they could facilitate good outcomes for patients.

All response times were recorded on the patient record form, this included allocation and arrival at scene and arrival at patient. These were duplicated onto the electronic job log which was available post patient contact. The service reported that whilst they recorded the response times they do not place as much emphasis on them since national targets had changed. This had resulted in community first responder attendance not counting towards national targets. They reported that this had also impacted on allocation of work to them as they were not as prioritised.

The average response times from November 2022 to October 2023 were; CEMS team- 28 minutes 38 seconds; community first responders- 11 minutes 06 seconds; Falls team- 27 minutes 08 seconds and the MEDIC50 team- 11 minutes 33 seconds. This was an overall average of 20 minutes 08 seconds response across all services.

Patient outcomes

Requires Improvement

Emergency and urgent care

Clinical audits were not always completed consistently. However, outcomes for patients were positive.

The service participated in clinical audits, however this was not always completed consistently. The service audited the use and management of controlled drugs. They selected two members of staff at random who would have their medicine stocks reviewed and also reviewed all of the vehicles that had a stock of controlled drugs. The results from the most recent audits from October 2023 showed a 96% compliance rate. The managers within the service could describe how learning would be shared depending on the results.

The service completed audits on the patient record forms for the community first responder teams. These were not always completed consistently due to the lack of capacity in the service delivery team. This meant that improvements required for the service might not be identified through this process. This was done on a monthly basis and involved randomly selecting staff members who would have a sample of their records audited. The service had a policy for escalation where records did not meet required standards and a letter template that would be sent to staff, if required, to share findings from the audits. This was in place for the community first responder teams and aimed to audit staff across the different levels. This was also not in place for the Falls or CEMS teams.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. The CEMS service aimed to discharge patients where it was safe to do so. 62.7% of patients were discharged at the scene following LIVES staff carrying out interventions. This number had increased in the years that the service had been operational due to the better targeting of patients that staff were sent to see. Non health care professional registered staff were not permitted to discharge patients themselves and if they thought that a patient did not require any ongoing care would need to seek advice and guidance from a clinician either within LIVES or within the NHS ambulance trust.

Within the critical care team depending on what interventions were provided this would trigger different audit cycles where staff had to input information online. This would then be reviewed by other clinicians to ensure that best practice guidance was followed. Any anaesthetics that were administered would be reviewed by the team to identify any areas of good practice or learning.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff had a workbook containing different skills, depending on their role, they were required to be competent in before they could be passed to work for the service. All volunteers starting with the organisation had a trained mentor assigned during their induction. This individual would support them through the first six months of working for LIVES and help them to sign off their competencies. This was also the case for the Falls team where they would be assigned a buddy for the first 6 months of their employment.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service predicted that 95% of eligible staff would have their appraisal completed by the end of the year. Where required this included managers shadowing staff on shifts and also using the services skills and simulation lab to demonstrate their skills. Volunteers were required to repeat all their training on a three yearly basis to ensure that they were skilled to carry out their roles.

The clinical educators supported the learning and development needs of staff. LIVES employed trainers and educators who were trained to deliver different courses and delivered accredited courses. The service also had live casualties who were staff members who were trained to act out being a victim in different emergency scenarios so that staff could practice their skills. Where staff required a course that was not available through the service, they would seek training from external providers. The service worked in partnership with a local University to deliver a post graduate certificate in pre-hospital critical care. They had supported 5 of their staff to complete this course in the last year.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The different services had development days throughout the year that were specific for the services they offered, these included training in key skills and skill development.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The medical director was in the process of creating a development pathway for paramedics joining the service so that they could become upskilled and enable them to carry out more interventions.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. This was discussed as part of their appraisals and any additional relevant courses staff were supported to attend. The service had supported staff members to complete Masters University courses.

Managers made sure staff received any specialist training for their role. Staff had access to a wide range of courses depending on their role.

Managers identified poor staff performance promptly and supported staff to improve. Managers could give examples of where poor staff performance had been identified, investigated and learning implemented.

Managers recruited, trained, and supported volunteers to support patients in the service.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. System partners fed back that they had open, positive working relationships with the service where improvements for patient care could be discussed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff had access to various pathways that they could refer patients through. They could access Occupational Therapists and an emergency community response team who would attend to the patient within two hours of the referral. They also worked closely with the local fire service who they would refer to if they felt there was a fire risk identified. Staff were focused on supporting patients to stay in their own homes if it was safe to do so.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. This would be done through the local ambulance service.

Health Promotion

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

The service had relevant information leaflets available for patients who had been treated by the CEMS team, this included advice on what they had been treated for and information for ongoing monitoring.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle. For the commissioned services, staff had access to additional health and wellbeing pathways that they could signpost patients to.

Staff supported patients to make decisions on their care and treatment where appropriate and also referred to other organisations so that patient's independence could be supported.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. Patients' capacity to consent was recorded in 9 out of the 10 records we looked at following the inspection.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

The provider had a consent policy which was in date, version controlled and had a review date. The key definitions, responsibilities, and processes to follow including gaining consent from children.

Requires Improvement

Emergency and urgent care

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff told us they had enough time to find out about the patient and their needs and preferences. They also told us that they look at the patient in a wider context and consider their care packages, home life, heating/food in the house, etc.

Patients said staff treated them well and with kindness. One patient reported; “All in all we thought what a remarkable team of kind professionals they were”.

Staff followed policy to keep patient care and treatment confidential. Staff told us how they stored patient records to ensure that confidentiality was maintained.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

Staff gave us examples of where they had helped to move furniture for patients so they could remain in their homes and also where they had put plans in place to support palliative patients to stay in their own homes safely.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Requires Improvement

Emergency and urgent care

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us they would spend as long as they needed with patients to ensure they were safe, well and happy before they left. They told us they offered to call family members to update them where needed. We were given examples where staff had sat with patient's families until support had arrived for them following their loved ones being conveyed to hospital.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff told us they were happy to make a cup of tea and spend time with patients (and their families) as well as provide treatment.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff explained how they would ensure patients and their families understood care and treatment options, where possible, before carrying out any interventions.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff speaking to patients in a kind, calm manner, checking to make sure they understood what was being discussed. Patients reported that they were 'put at ease' by staff.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff had a postcard that had information on how to raise concerns or compliments that they left with the patient, their families, or other professionals in attendance. Once a month a random selection of patients were selected, and a letter sent out to gather their views on the service.

Staff supported patients to make informed decisions about their care. This included helping them to make decisions on treatment options and with being referred to other services.

Is the service responsive?

Good

We rated responsive as good.

Service delivery to meet the needs of local people.

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

Requires Improvement

Emergency and urgent care

Managers planned and organised services, so they met the needs of the local population. The service was designed to meet the needs of the rural population of Lincolnshire. The community first responders were spread across the county to try to provide cover across all areas. The critical care team were developed to provide a service to help to reduce the inequality in the access to major trauma centres for the people of Lincolnshire by allowing senior clinicians to treat patients in the community to stabilise them prior to being transferred up to two hours to major trauma centres.

Leaders in the service were focused on ensuring that the people of Lincolnshire were not disadvantaged by the rurality of the county. They worked with system partners to review areas where there was higher demand so that recruitment of community first responders could be targeted where it was needed.

Leaders of the service were involved in multiple systems and boards that worked across the local area. These groups were responsible for steering the health and wellbeing of the communities they served. Some of the leaders were also involved in national organisations.

Facilities and premises were appropriate for the services being delivered. The service had plans to move to a new, purpose-built building which was hoped would expand the staff wellbeing offer.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff told us that they did not have time pressures when attending to patients and that this allowed them to treat patients holistically and helped to ensure the best outcomes for patients. During our inspection we heard examples where staff and volunteers had supported patients and their families to enable them to stay at home.

The service had links with other services in the county. This meant that patients could be referred for other support where needed, such as for a same day Occupational Therapy assessment or to get specialist equipment. They also had links with the county's fire service where they could refer patients if they identified fire risks in the home.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had good links with the local system so could refer patients to other services when needed.

Managers made sure staff, and patients, loved ones and carers could get help from translation services when needed. This was provided through a telephone or online service. Staff knew how to access these services.

Staff had access to communication aids to help patients become partners in their care and treatment. These included picture cards for helping patients to rate their pain score.

Access and flow

Staff were available to offer people access to the service when they needed it. However, work was not always allocated in a timely way by the ambulance trust.

Managers told us they had no control over access and flow arrangements of work allocation. Due to the varying nature of the service delivered each vehicle/volunteer logged onto the system at the start of their shift which alerted the ambulance control centre as to who was available and their skill level for work to be allocated.

The main risk identified by the leaders of the service was around the allocation of work to their staff from the ambulance trust. Over time this had led to a reduction in the number of patients being seen by the service. 3 years ago, volunteers across the service would be logged on available to take calls for an average of 9 hours before they were allocated a job to do. From January to March of this year this figure was 17.5 hours. Leaders told us that this was having an impact on staff morale. For 2022 the service logged 70,000 hours of volunteer hours available for the ambulance service to use. This was being raised with the ambulance service at all levels of governance and leaders told us that there were plans in place to see improvements in this.

The commissioned services had a key performance indicator of 95% service delivery for the Falls and CEMS teams. From July 2022 to March 2023 the CEMS team had an availability of 77.22% and the falls team 83.84%. From April 2023 to the time of our inspection the CEMS team had an availability of 82.87% and the falls team 82.78%.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, including those in partner organisations.

Patients, relatives, and carers knew how to complain or raise concerns. The service had 5 complaints raised in the last 12 months and 2 concerns raised. The service had 239 compliments shared through the same process.

The service clearly gave patients information about how to raise a concern or compliment. After seeing a patient staff members would give out a card to patients or their family members which gave information on how to feedback about services. This information was also contained on the services website.

Staff understood the policy on complaints and knew how to handle them. The provider had a complaints policy, was due for review in November 2023. Complaints or concerns were usually received via email and were logged on a complaint's tracker excel file. They were then allocated to different members of staff depending on the nature of the complaint.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. This was evidenced in the complaints we looked at during the inspection.

Managers shared feedback from complaints with staff and learning was used to improve the service. This could be done on an individual basis or via the services bulletins if a wider change was required.

Staff could give examples of how they used patient feedback to improve daily practice.

The service did not use any one particular independent complaints review service but instead would be flexible and hire in independent reviewers based on their experience.

Requires Improvement

Emergency and urgent care

Is the service well-led?

Requires Improvement

We rated well-led as requires improvement.

Leadership

There had been a recent period of instability in leaders in the service. However, at the time of our inspection leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, not all staff felt they could raise concerns to managers.

The CEMS leadership team had undergone a period of instability over the last year. In the two months prior to the inspection the service had a new clinical lead in post, a temporary operational manager and a medical director who provided direct clinical leadership for the service. This period of instability had resulted in staff leaving or being from clinical duties leaving the available staff in the team reduced. The new leadership team for the service had a clear vision for the service and had plans in place to address the concerns.

Staff told us that leaders across the service were visible. They ensured staff had leadership/operational support 24 hours per day via an on-call system. There was also a clinical on-call system where staff could access experienced clinicians for advice. However, not all staff felt they could raise concerns to managers and feared consequences for doing so.

As part of staff appraisal, career development plans were discussed and any training opportunities required were identified as part of this process. There were examples throughout the organisation of people developing their skills, securing permanent employment, and also taking on more senior roles within the organisation.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a vision and strategy. The services vision was that no person should suffer unnecessarily as a result of their illness, injury, or their rural location. The mission was to provide equality and excellence of care to any person who suffers a medical or traumatic emergency within Lincolnshire.

The provider had three main values:

- Integrity- Our strength comes from working together and upholding shared values. We do the right thing, even when its difficult.
- Community- This is where we're from, we're in this together. We're all united around a common purpose; to support the communities in which we all live.

- Excellence- We strive to be the best we can in everything we do and to give all of our people an equal opportunity to grow and flourish.

The service had a strategy which covered 2020-2025. The aims for the five years were to: understand their impact; grow their impact; focus on quality; financial stability and excellence in governance. The service also had a strategy specific for each of the services it delivered.

All projects that were undertaken were linked back to the vision and strategy for the organisation. These were monitored through the various governance committee and the charity board had overall oversight of the vision and strategy.

Culture

Not all staff felt respected, supported, and valued. However, all staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

Not all staff felt supported, respected, and valued. Some staff told us they were not able to raise concerns or improvements to their managers as they did not feel listened to and feared the consequences. They shared that there were allegations of bullying and shouting at staff in public areas from senior leaders. However, staff said they had felt unable to report these allegations formally. They described staff having 'disappeared' from work with people not sure if they had left the company or were on sick leave. Staff also told us they did not feel comfortable in raising concerns to the human resources service as they did not feel that investigations were always completed. The management team told us that investigations were completed but were kept confidential and only shared with those involved. This had resulted in a number of staff being absent through sick leave and also ongoing HR processes & suspensions. Managers within the service identified some of the concerns raised by staff but told us that they could not communicate confidential information about individuals sickness or disciplinary processes to other staff members.

However, the culture was centred on the needs and experience of people who used services. All staff we spoke with were passionate about the job they did and focussed on the needs of the patients they served.

The service had a number of ways of supporting staff welfare. When patients completed summaries of their jobs, they had the option to tick to say they needed support as well as automatically flagging if certain key words were used. This would then be passed to the relevant person who would contact the individual to offer support. The service had trained mental health first aiders who could offer support to staff and also delivered that training for other organisations.

Staff had access to wellbeing action plans which staff were encouraged to use, and wellbeing was discussed as part of the appraisal process. The service also had a contract with an external company who delivered an employee assistance programme which was accessible by employees, volunteers, and their families. This provided support on a number of different topics, and everyone was eligible for 6 episodes of free counselling up to 3 times a year.

The service had a freedom to speak up guardian but identified that this was something that needs to be developed and had been identified as a focus for the next six months.

Governance

Requires Improvement

Emergency and urgent care

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes, and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. All levels of governance and management functioned effectively and interacted with each other.

The four main governance committees were:

- Clinical governance committee- within this there were safeguarding review, medicines, and equipment review, learning from events review and clinical governance review groups.
- People and organisation committee- within this there was an education development subgroup.
- Finance and performance committee
- Risk management committee

There was a LIVES advisory group which was made up of representatives from across the employed and voluntary teams. Two members from this group sat on each of the four main governance committees. Each committee also had a minimum of one trustee who was a member of the group. The governance groups met quarterly with the board meeting quarterly and the board also completed two board development sessions a year.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. At the time of our inspection the service did not have a business continuity policy that reflected current service provision.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements monitored.

There were arrangements for identifying, recording, and managing risks, issues, and mitigating actions. The service had an overarching risk register and also a separate risk register in relation to the CEMS service due to the challenges it had faced. There was alignment between recorded risks and what staff said was 'on their worry list'. Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Managers of the service identified the biggest risk of the service was the issues with the local ambulance services control centre for which the service relied on their allocation of work. They gave examples of where they had met with the

service to share their concerns and reflected that this was an ongoing concern. However, in the last 6 months the managers felt that there had been a positive shift in the discussions to being more solution focussed. The ambulance service was undergoing a change in systems that LIVES recognised would make allocation of work to them harder in the short term but hoped that it would have a positive impact longer term.

The service had a risk management committee which met quarterly. All risks were reviewed on a 3 month, 6 month or yearly basis. The role of committee was to review risks that are up for review and to change score if needed. The committee had a trustee who chaired the meeting and then fed back information to the wider trustee group.

At the time of our inspection the service did not have a business continuity policy that reflected current service provision. However, the service had recently started work on their business continuity planning; they had plans in place to review their old policy and to update this in line with their current business model and current guidance. The provider had plans to recruit business continuity and health and safety champions from across the organisation who would help share learning and information across their areas. The service was also looking at how they would feed into the local systems major incident planning and how this would look for the different teams.

We saw evidence the provider had three key contracts for servicing equipment depending on the type of equipment. This reduced the risk of the provider being without equipment which could impact upon the ability to provide the service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. However, the service did not submit any safeguarding notifications to us.

Information was used to measure improvement, not just assurance. Both quality and sustainability received coverage in relevant meetings at all levels.

Staff had sufficient access to information and challenged it when necessary. At the time of our inspection 98% of staff had completed their data security training. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage, and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care. The service met regularly with commissioners and system partners to share information and to review processes.

The service had not submitted any safeguarding notifications to the Care Quality Commission (CQC) despite them submitting notifications to the Local Authority. As part of their registration requirements with us, providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services.

There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records, and data management systems, in line with data security standards. Lessons were learned when there were data security breaches.

We reviewed the providers data protection policy. This outlined how the provider would ensure the confidentially of the information it used would be stored in accordance with the legislation.

Requires Improvement

Emergency and urgent care

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups, people who used services, and those close to them. Staff had a postcard that they left with patients or their families which gave information on the charity and how to raise concerns or compliments. We saw evidence of feedback that had been given to the service. Staff also had access to a service-to-service feedback card which was given to other professionals who attended to the patient at the same time.

The service linked in with the ambulance trusts patient complaints team where required to help investigate complaints/ concerns. The service also sent a letter out to a random selection of patients, using details on their patient record forms to gather their views of the service.

Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture.

The service had a LIVES advisory group which was made up of representatives from across the county and from every work area. This was attended by approximately 15 different members and was regenerated every 18 months to look for new volunteers. This group met with senior leaders quarterly to share their ideas or concerns from the different teams with a member of the trust board also being part of the group. 2 members from the LIVES advisory group also sat on each of the governance committees.

Community first responder teams had a yearly survey to gather their views of the service. The leaders had also just completed a pulse survey to get a months' worth of data to gather their views. Each district had a quarterly meeting which was open for all volunteers to attend. The leaders for the service and from head office also made visits out to the districts and had online question and answer sessions.

The CEMS and falls teams also had regular team meetings and development days where there were open discussion sessions for staff to feedback. They had also done weekly pulse surveys to gather the views anonymously due to the challenges in the team. Head office staff had a team meeting once a month. All employed staff also had a staff survey which was last completed in October 2022.

The service communicated key changes and information through an online bulletin system. Updates were coordinated depending on their urgency. They could be green which were collated monthly, amber which were collated weekly or red which were urgent and sent out daily. During the inspection we saw evidence of these being sent out following changes in national guidance and incidents.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance. Stakeholders fed back that they had positive relationships with good communication with the service.

Learning, continuous improvement and innovation

Requires Improvement

Emergency and urgent care

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff aspired to continuous learning, improvement, and innovation. This included participation in appropriate research projects and recognised accreditation schemes. Staff during the inspection told us about a number of research projects and pilots they were part of. They included being part of research projects within universities. Looking at how technology can be used to improve patient care and to assist with training. Also, a recent project had been set up to ensure that patients were not delayed in getting blood transfusions when they need it which had already had positive impacts on patient's outcomes.

Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service.

LIVES had been recognised in a number of awards:

- Lincolnshire Fire & Rescue Recognition Awards 2023. This was a Partnership Working Awards presented to LIVES, Lincs & Notts Air Ambulance and Lincolnshire Fire and Rescue. This award was in recognition of the work that the three partners had done to launch the Biker Down road safety programme as an education programme across Lincolnshire.
- Boston Borough Council Boston Hero Awards. The Boston District Community First Responders won Community Group of the Year for their efforts in responding to medical emergencies across Boston.
- South Kesteven District Council – Neil Smith Beyond the Call of Duty Award. David Harvey, CFR in the South West District, was shortlisted for his extraordinary work in teaching CPR to children and young people in schools across the District.
- LIVES Education Direct Claim Status. LIVES Education has been recognised for its commitment to quality in the delivery and administration of training through the award of Direct Claim Status (DCS) with all of our accrediting entities. This means that LIVES Education can certify accredited courses independently without referent to the awarding body, thanks to their rigorous internal quality assurance procedures and quality of education delivery. This capability was reaffirmed during their recent External Quality Assurance (EQA) visit in November 2023, where our DCS status was successfully reaccredited with one of their awarding bodies QNUK.
- LIVES Education Accreditations. They been accredited to deliver three suites of renowned and internationally recognised pre-hospital education courses in the last 12 months.
- They have obtained exclusive rights to deliver The Difficult Airway EMS suite in the Midlands and East of England.
- They are the second national centre to provide the innovative PANDA course, designed to enhance pre-hospital perception and treatment for injured/sick children.
- Defence Employers Recognition Scheme- LIVES holds the Silver Award in the Defence Employers Recognition Scheme with recognises employers that pledge, demonstrate and advocate support to the defence and armed forces community and align their values with the Armed Forces Covenant.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure it audits staff's adherence to its infection control policies and procedures. (Regulation 17) • The service must ensure staff fully complete risk assessments, including NEWS scores, for patients and update them where required. (Regulation 17) • The service must ensure that patient record audits are consistently completed. (Regulation 17) • The service must ensure that it continues to work on the culture of the organisation so that staff feel able to raise concerns. (Regulation 17)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service must ensure they have enough staff to safely deliver services. (Regulation 18 (1)) • The service must ensure guidelines from staff on restraint of patients are clear and consistently followed. If this includes restraining patients, then staff must be trained to do this safely. (Regulation 18 (2))