

The Air Ambulance Service

Warwickshire & Northamptonshire Air Ambulance & Children's Air Ambulance

Quality Report

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

Ratings

Overall rating for this ambulance location

Emergency and urgent care services

Summary of findings

Letter from the Chief Inspector of Hospitals

Warwickshire & Northamptonshire Air Ambulance Service is operated by The Air Ambulance Service. The service provides emergency and urgent care and a patient transport service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 15 and 16 January 2018.

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

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

The main service provided by this service was emergency and urgent care. Patient transport services were a small proportion of activity. Where arrangements were the same, we have reported findings in the emergency and urgent care section.

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:

- There was an effective system and policy in place to report and respond appropriately to incidents. Learning was shared.
- There were effective systems and processes in place to protect people from the spread of infection, to ensure safe storage and administration of medicines and to safeguard patients from the risk of abuse.
- The maintenance and use of equipment kept patients safe from avoidable harm during treatment and transfer in the aircraft or vehicle.
- Patients' individual care records were written and managed appropriately. Appropriate protocols were in place to assess and respond to patient risk. Staff had access to relevant information when needed.
- Staffing levels and skill mix were planned and reviewed to ensure that people received safe care and treatment at all times.
- The service planned for any anticipated risk and these were outlined in the business continuity policy. Staff understood their roles in a major incident.
- The care and treatment of patients was based on nationally recognised guidance. The service monitored compliance against its own key performance indicators (KPIs) to continue to drive improvements in patient outcomes.
- Staff had the skills, knowledge, and experience to deliver effective care and treatment.
- Care was delivered in a coordinated way with all other services involved. Effective and positive multi-disciplinary working was clearly evident.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA).
- Care was provided in a sensitive and dignified way, wherever possible. Feedback received was very positive. Staff kept patients and families well informed regarding the treatment taking place on the scene and the plan ahead, including which hospital they would be transferred to.
- The service effectively planned and delivered services based on patient needs and were planned to take into account the different needs of the type of incidents and patients they responded to.
- Patients had access to timely care and critical care treatment.
- Effective procedures were in place to respond and learn from complaints.

Summary of findings

- Leaders had the skills, knowledge, experience, and integrity they needed to ensure the service met patient needs.
- The service had a clear vision and strategy, underpinned by holistic values that were embraced by all staff at every level.
- Governance and risk management systems were effective in maintaining a clear oversight of the safety and high quality of services delivered.
- The service had an open and learning culture, fully focused on safe and high quality patient care.
- Staff and public engagement was positive and designed to seek feedback to continue to improve the service.

However, we also found the following issues that the service provider needs to improve:

- The safeguarding adults' policy referenced out of date guidance. This was raised with the registered manager during the inspection who took immediate action to update the policy.
- Aircraft pilots had not had safeguarding training.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Please refer to the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Rating Why have we given this rating?

The service was well led with experienced and capable leaders who drove improvements in the service with a focus on the best possible care in emergency situations for patients in need. The leaders promoted a positive staff culture and encouraged staff development to deliver the best possible care and treatment for all patients. Effective systems were in place to ensure patients received safe and high quality care and treatment at all times.

Warwickshire & Northamptonshire Air Ambulance & Children's Air Ambulance

Detailed findings

Services we looked at

Emergency and urgent care

Detailed findings

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Background to Warwickshire & Northamptonshire Air Ambulance & Children's Air Ambulance

Warwickshire & Northamptonshire Air Ambulance Service is operated by The Air Ambulance Service. The service is a charity and opened in 2003. It is an independent ambulance service based in Coventry and the service primarily serves the communities of Warwickshire and Northamptonshire. It also provides support for transporting children across England and Wales.

The Warwickshire & Northamptonshire Air Ambulance is a critical care Helicopter Emergency Medical Service based at Coventry Airport. Warwickshire & Northamptonshire Air Ambulance began operations in October 2003 providing critical care services to both main local NHS ambulance foundation trusts and mutual aid to neighbouring NHS ambulance service NHS trusts. It operates from 7am to 2am.

The service also operates a critical care rapid response vehicle out of hours (and when the aircraft are off-line) currently between the hours of 4pm to 2am.

In 2012, the Children's Air Ambulance launched its service operating from the same operational base as the Warwickshire & Northamptonshire Air Ambulance at Coventry Airport. The Children's Air Ambulance is the first and only national service dedicated to transferring neonatal and paediatric patients and clinical teams (when patients are too sick to fly) from local district hospitals to specialist care/treatment centres across the United Kingdom. Different to the helicopter emergency medical services, clinical teams for the Children's Air Ambulance are provided by dedicated NHS specialist transport teams. The children's air ambulance operated from 9am to 7pm.

The service has had a registered manager in post since 2011. The current registered manager has been in post since 2014. We carried out an announced inspection on 15 and 16 January 2018. We spoke with 12 members of staff, including the Chief Executive, Director of Operations, Director of Human Resources, pilots, doctors and critical care paramedics.

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 ambulance services. The inspection team was overseen by Phil Terry, Inspection Manager.

Detailed findings

Facts and data about Warwickshire & Northamptonshire Air Ambulance & Children's Air Ambulance

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the Fire and Rescue Building, Coventry Airport in Coventry. We spoke with 12 staff including critical care paramedics, pilots, and management. During our inspection, we reviewed 24 sets of patient record forms.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in February 2014, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (January 2017 to December 2017):

- Total missions for helicopter: 858 (an increase from 800 in the previous year).
- Total missions for Rapid Response Vehicle: 663 (an increase from 413 in the previous year).

Staffing establishment was for 11 staff for the air ambulance and eight for the children's air ambulance. There were no vacancies at the time of the inspection.

The accountable officer for controlled drugs (CDs) was the base manager.

Track record on safety:

- No never events
- Clinical incidents: 16 no harm, zero low harm, zero moderate harm, zero severe harm, zero death.
- No serious injuries.
- One complaint.
- There have been no liability claims in the last 12 months.

Emergency and urgent care services

Safe

Effective

Caring

Responsive

Well-led

Overall

Information about the service

The main service provided by this service was emergency and urgent care. Patient transport services were a small proportion of activity. Where arrangements were the same, we have reported findings in the emergency and urgent care section.

Summary of findings

We found the following areas of good practice:

Safe:

- There was an effective system and policy in place to report and respond appropriately to incidents. Learning was shared.
- The service had effective systems in place to monitor staff's compliance with mandatory training.
- There were generally effective systems and processes in place reflecting relevant safeguarding legislation to safeguard adults and children from abuse.
- There were effective systems and processes in place to protect people from the spread of infection and to ensure safe storage and administration of medicines.
- The maintenance and use of equipment kept patients safe from avoidable harm during treatment and transfer in the aircraft or vehicle.
- Patients' individual care records were written and managed appropriately.
- Appropriate protocols were in place to assess and respond to patient risk.
- Staffing levels and skill mix were planned and reviewed to ensure that people were safe from avoidable harm and received safe care and treatment at all times.
- The service planned for any anticipated risk and these were outlined in the business continuity policy. Staff understood their roles in a major incident.

Effective:

- The care and treatment of patients was based on nationally recognised guidance.

Emergency and urgent care services

- The service monitored compliance against its own key performance indicators (KPIs) to continue to drive improvements in patient outcomes.
- Staff had the skills, knowledge, and experience to deliver effective care and treatment.
- Care was delivered in a coordinated way with all other services involved.
- Effective and positive multi-disciplinary working was clearly evident.
- Staff had access to relevant information when needed.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA).

Caring:

- Care was provided in a sensitive and dignified way, wherever possible. Feedback received was very positive.
- Staff kept patients and families well informed regarding the treatment taking place on the scene and the plan ahead, including which hospital they would be transferred to.
- Staff we spoke with understood the impact that a person's care, treatment, or condition would have on their wellbeing and those close to them, both physically and emotionally.

Responsive:

- The service effectively planned and delivered services based on patient needs.
- Services were planned to take into account the different needs of the type of incidents and patients they responded to.
- Patients had access to timely care and critical care treatment.
- Effective procedures were in place to respond and learn from complaints.

Well led:

- Leaders had the skills, knowledge, experience, and integrity they needed to ensure the service met patient needs.

- The service had a clear vision and strategy, underpinned by holistic values that were embraced by all staff at every level.
- Governance and risk management systems were effective in maintaining a clear oversight of the safety and high quality of services delivered.
- The service had an open and learning culture, fully focused on safe and high quality patient care.
- Staff and public engagement was positive and designed to seek feedback to continue to improve the service.

However, we found the following issues that the service provider needs to improve:

Safe

- The safeguarding adults' policy referenced out of date guidance. This was raised with the registered manager during the inspection who took immediate action to update the policy.
- Aircraft pilots had not had safeguarding training.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- There was an effective system and policy in place to report and respond appropriately to incidents. The incident reporting system was paper based. Incident forms contained details of the incident facts and the immediate action taken. The base manager reviewed each form and took the appropriate action to investigate the incident. Following the investigation, there was a record of any learning and actions taken. These were shared to all staff by email and the communications page on their intranet. Where appropriate, the service requested other organisations to investigate incidents where they had been involved.
- Incidents were discussed between the senior management team at the time of reporting and as an agenda in team meetings. We saw evidence of this in the meeting minutes.
- There had been no reported never events from January 2017 to December 2017. 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. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There had been 16 incidents reported from January 2017 to December 2017. We reviewed the five most recent reported incidents. These included equipment malfunctions, safety of other personnel at an incident site and communication issues with another healthcare provider. We saw that the staff were included in the investigations when needed. There were no serious incidents or incidents that resulted in harm.
- Staff were aware of the process for reporting incidents and accidents. They told us that there was a full debrief for the staff involved and they did receive feedback. They said that the senior management team and staff were open and transparent in the reporting and investigation of incidents.
- Staff were able to identify changes to practice which had occurred as a result of the incident reporting process. For example, they had experienced a number of

incidents where ampoules containing medicines were broken in the medicine bags during use in the helicopters. The ampoules were now placed into a hardened protective case before going into the emergency response bag.

- Any incidents involving the aircraft were investigated in line with the Civil Aviation Authority regulations. An electronic overview of all incidents reported was maintained by the service. The electronic record included a description of the incident, the level of risk and the outcome with included recommendations.
- Providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation requires staff to be open, transparent, and candid with patients and relatives when things go wrong. The service has a policy in place, which described their responsibilities under the Duty of Candour legislation. Staff we spoke with understood the requirements of Duty of Candour and their role with regards to honesty.

Mandatory training

- The service had effective systems in place to monitor staff's compliance with mandatory training.
- Staff received mandatory training in safe systems, practices, and processes. There were 11 identified mandatory modules. Topics included, infection prevention and control, health and safety, information governance and mental capacity. All staff had completed training in eight of the modules. The lowest level of completion was 87% for the personal safety module. Remaining staff were reminded that this was needed to be completed via email. The service did not have a compliance target.
- The service had recently employed a learning and performance manager. Their predominant role was to arrange and ensure that all staff were up to date and receiving appropriate training, using a database that detailed skills and training. The completion date was

Emergency and urgent care services

included and when it was up for renewal. Staff had a protected time of 30 minutes a day designated for aviation and clinical briefings. Staff could also access the e-learning modules at home, if they wished.

- The service required evidence from doctors' current NHS role of their compliance with mandatory training. This information was then recorded in the individuals' staff file.
- Staff had completed the relevant driver training, and this included 'blue light driving' when required. All paramedics had Institute of Healthcare and Development (IHCD) ambulance driving training. The head of operations held a register of employees who were deemed competent to drive on emergencies. Managers realised there was a need for driver assessments and refresher training and planned additional 'blue light' driver training for 2018. They arranged for an instructor from the local NHS ambulance service to deliver refresher courses to paramedics.

Safeguarding

- There were generally effective systems and processes in place reflecting relevant safeguarding legislation to safeguard adults and children from abuse. However, the safeguarding adults' policy referenced out of date guidance. This was raised with the registered manager during the inspection who took immediate action to update the policy.
- The policies were easily accessible in paper and electronic form. The policy outlined what safeguarding was, its importance and provided definitions to the different types of abuse. The policy also covered staff responsibilities about raising safeguarding concerns and the procedure by which to report these.
- The service's critical care paramedics received level two safeguarding children and adult training and the doctors had received level two or three safeguarding children in accordance with their training requirements with their NHS trust. Staff were 100% compliant with the required training.
- The 'Safeguarding Adults: Roles and competences for healthcare staff – Intercollegiate Document' (2016), states that all non-clinical and clinical staff who have any contact with children, young people, and/or parents/carers should be level two trained. This trains the health care professional to recognise signs of abuse and appropriately refer to the relevant services. We

discussed the levels of training with the registered manager and looked at the national guidance from the National Ambulance Safeguarding Group. The service was meeting national guidance in that paramedics did not need level three training, as they are not involved in the assessing, planning, evaluating, and contributing to the plans of children where safeguarding concerns are already known.

- Where a safeguarding concern was identified, it was referred to the relevant tasking ambulance trust immediately. This was then followed up and investigated by a safeguarding children level four trained safeguarding lead who would make the required referral to social services.
- All staff spoken with were aware of what to report and how to make a safeguarding referral when required. Staff we spoke with were knowledgeable about the processes for recognising and referring a safeguarding concern. A member of staff gave an example of a safeguarding referral they had made, and how they linked with the relevant NHS ambulance service to ensure the child was safe.
- We spoke with the requesting NHS ambulance service and they told us that the systems and processes that were in place worked well in safeguarding children and both services communicated well together.
- We saw that the pilots had not received any formal safeguarding training. They were subcontracted from an external aviation company. Although they had not received formal training, they all had read the policy and knew the process for recognising and referring concerns. The registered manager told us that the service would now include the pilots on mandatory safeguarding training.
- All staff had completed training in preventing radicalisation and extreme terrorism ('PREVENT' training). Female Genital Mutilation (FGM) was included in level two safeguarding training, which all clinical staff attended. Staff were aware that they have a mandatory reporting duty to report any cases of FGM in females under the age of 18 years of age, including those females who had given birth to a female infant. This awareness may have come from physical examination or from a verbal disclosure. Staff knew their responsibility to report this to the Police within 24 hours ideally but certainly within 28 days after being made aware of the FGM.

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- Child Sex Exploitation (CSE) was included in level two safeguarding training. CSE is a form of child abuse and reportable to children's social services in line with safeguarding procedures. Staff were aware of the potential indicators of abuse, and how to complete an interagency referral.

Cleanliness, infection control, and hygiene

- There were effective systems and processes in place to protect people from the spread of infection. The service was able to demonstrate how they assessed the risk of infection and took action to prevent, detect, and control the spread of infections.
- The service had a policy in place for infection prevention and control. This had been reviewed in a timely manner. This included advice and guidance for staff to follow including, hand hygiene, the use of person protective equipment (PPE), vehicle and aircraft cleaning, sharps injuries and managing patients with specific infections.
- There was evidence that showed that patient-related infection prevention and control risks were considered and managed appropriately prior to each mission. Information was collected to make sure staff were prepared and the aircraft was cleaned in accordance to the policy before and after each mission. There were cleaning records for the aircraft and rapid response vehicles. We also saw records of regular 'deep cleaning' carried out regularly.
- We looked at the aircraft and rapid response vehicle and both were visibly clean and tidy. Ambulance interior surfaces and equipment were visibly clean and records of daily checks had been completed.
- Uniforms were laundered onsite at correct temperatures and the linen used on stretchers were disposable.
- The base manager completed monthly audits of infection prevention and control. These consisted of checks of the cleaning records for the aircraft and vehicles, temperature checks of the refrigerators and freezers and toilet cleaning. Compliance with the audit criteria was 93% for November 2017 and 96% in December 2017: the services target was 90%. The audit identified some issues with the cleaning of the base when the domestic staff member was on annual leave. This had been addressed and actioned.

- We saw evidence of clinical staff using hand gels and PPE during missions and with each patient contact. PPE was readily available in all vehicles we looked at. Appropriate hand washing facilities and hand gels were in place to be used by staff.
- There were arrangements for managing waste and clinical waste. On the aircraft and vehicles were a selection of waste bags, including clinical waste bags and spillage kits. Once on the ground these were disposed of at the base in a clinical waste bin. A specialist contract was in place for collecting clinical waste, including sharps. This bin was locked and stored appropriately. There were colour-coded bins in place for both general and clinical waste. Clinical waste was stored on site at the service's office, and was collected at prearranged times when necessary.
- The service had an infection control lead for the organisation, who staff could access for advice and support.
- We saw that staff had received infection control training as part of induction and annual mandatory training.
- The manager informed us that no incidents relating to infection control had been reported in the past year.

Environment and equipment

- The service had effective systems in place to ensure the safety and maintenance of equipment. The maintenance and use of equipment kept patients safe from avoidable harm during treatment and transfer in the aircraft or vehicle.
- The aircraft was checked prior to being flown by a suitably trained technician. Aircraft had to meet the requirements of the Civil Aviation Authority (CAA). A maintenance contract was in place for the maintenance and servicing of the aircraft. We saw evidence of these documents. The company the aircraft was loaned from supplied another helicopter when it was being serviced.
- The maintenance and servicing of the three rapid response vehicles was carried out by a neighbouring NHS ambulance service. We saw that all vehicles had valid and appropriate vehicle insurance and evidence of regular service and maintenance. The service was compliant with Ministry of Transport (MOT) testing and servicing of the vehicles. Staff told us that they were contacted when an MOT or service was due. The service

Emergency and urgent care services

also kept a record to ensure the vehicles were called for service in a timely manner. We saw regular maintenance and servicing had been carried out and that all vehicles were fit for use.

- The premises was secure. The aircrafts were kept in a locked hanger overnight. Access to the site was via an identification 'swipe card' and fingerprint ID locks. All visitors were escorted onto and off the site. CCTV was also in operation.
- Medical equipment was stored and ready for use. Clinical staff checked the medical equipment on a daily basis. This ensured the equipment was working and whether additional equipment was needed. Equipment for children and babies was also stored and checked appropriately ready for use. The 'kit bags' were reviewed and checked on a monthly basis. Senior staff told us each month kit bags were opened, checked, and re-sealed to make sure all equipment was in place and consumables were in date. All equipment and medical supplies seen were fit for use. Appropriate storage facilities were available and secure.
- The service had arrangements in place with a local NHS hospital for the servicing of all medical equipment. This was done in a planned manner in December each year. Records seen evidenced this.
- Stretchers used to transfer patients had pressure-relieving qualities within the mattress. It also had a weight limit of 20 stone. Due to the small environment inside the aircraft and weight limits due to fuel consumption, meant that some heavier patients could not fly. They still provided the care and treatment at the incident site, but the patient would then be transferred to the appropriate NHS hospital via a land ambulance, accompanied by a clinician from the service if the patient required on-going critical care support.
- A system was in place for the management of faulty equipment. If a piece of equipment was identified as being faulty, it was removed from use and documented on a record sheet. Arrangements were made to fix the fault so it could be returned as swiftly as possible. The service had back up equipment to use whilst items being fixed.
- Staff were trained on all the equipment used by the service to ensure they were competent to use it. This observed practice was documented in the staff's competency checklist and kept in staff files.
- The service had effective systems in place to ensure the safe storage and management of medicines.
- The service had a medicines' policy in place, which reflected current practices in medicine, such as, ordering, storage, and disposal. It referenced up to date information from the most recent legislation and guidance. The policy gave guidance on the safe handling, storage, and disposal of medicines, including gases.
- Medicines were securely stored in a locked room, which was only accessible to clinical staff by their individual 'swipe cards'. Stock checks and audits of all medicines were carried out weekly. Records seen evidenced this.
- There was a specific fridge for storing medications. The temperature was checked daily and all were within acceptable limits. This fridge was kept locked.
- The service held a stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). The Home Office controlled drug licence was on display. Controlled drugs were kept securely in accordance to the legislation. The controlled drug register showed the transfer of controlled drugs with the aircraft and regular stock checks were completed. Records seen evidenced this. During the mission, controlled drugs were stored in a locked crew bag and access limited to clinical staff only. There was a specific management of controlled drugs policy. The base manager was the accountable officer for controlled drugs.
- Medicines taken on missions were standardised and stored in specific bags. Two members of clinical staff checked out the medicines at the start of a shift and checked back in after each mission. Medicine administration was clearly documented in patient records.
- Paramedics are allowed to purchase and possess a number of controlled and prescription only medicines for parenteral administration, in accordance with schedule 17 of The Human Medicines Regulations 2012, 'schedule 17'. For medications that were not on schedule 17, for example, antibiotics and medication to treat or prevent excessive blood loss, the service had appropriate patient group directions (PGDs). These were detailed and had been reviewed regularly. The critical care paramedics had received appropriate training on PGDs.
- We saw suitable arrangements in place to action medicine safety alerts and recalls.

Medicines

Emergency and urgent care services

- The service kept a stock of medical gas cylinders. This was secure in a locked area. The service had plans in place for the clinical staff to liaise with the pilot when oxygen was in use. Medical gases were stored appropriately on the aircraft.

Records

- Patients' report forms (PRFs) were written and managed in a way that kept patients safe from avoidable harm. We found patients records to be accurate, complete, legible, up to date and stored securely.
- There was a policy in place for the storage, transport, and destruction of patient's records.
- Due to the service responding to trauma and medical emergencies, not all patient information was available before staff were dispatched, therefore the patient record was commenced at scene and was brought back to the base. A copy of the patient's record was provided to the NHS ambulance service that requested the mission. Appropriate processes were in place for the storage and destruction of patient records.
- We observed the helicopter's emergency medical doctor completing the patient record on scene. This was a thorough process, carried out with the ground ambulance staff. They made sure all medications were signed for and the patient's details were correct.
- Staff had completed training in data protection and information governance as part of their mandatory training. Compliance was 100% for these modules.

Assessing and responding to patient risk

- Appropriate protocols were in place to assess and respond to patient risk. The service provided a doctor-led model, which took critical care to the patient. Due to the acute nature of the emergency service they provided, staff could not carry out individual risk assessments of patients. Instead, the service designed specific learning scenarios, which would look at all risks involved in responding to a drowned patient, diving accidents, and multi-car road traffic accidents. These scenarios looked at all risks including access and equipment needed.
- During the flight, the critical care paramedic, doctor and the pilot were continually discussing any risks that may lie ahead. Such as difficult landing sites and risks to the public. This was done informally, but effectively. We observed this process on a mission. This was then documented once they got back to base.

- The service used the Joint Royal Colleges Ambulance Committee (JRCALC) guidance and National Institute for Health and Care Excellence (NICE) guidelines for sepsis and the management of the deteriorating patient.
- All patients were monitored during the mission to help detect deterioration in any condition. All paramedics had a critical care qualification and the doctors had a pre-hospital emergency care qualification. The PRFs showed that all patients were monitored appropriately and deterioration was recognised and treated.
- There was an on call system, which could be used for advice. Staff gave us an example of when this was used. A doctor needed a second opinion before they carried out a limb amputation on scene: this was discussed with the senior on call doctor, and the decision was made in the best interests of the patient. All calls were logged, so they could be used for discussion and learning in team meetings.
- Due to the nature of their work, the patients would be sedated and/or intubated, if applicable, prior to loading into the aircraft. Violent or behaviourally challenging patients would not be allowed to be transferred in the aircraft, so treatment would be carried out on scene, and then the police, with the land ambulances, would transfer them to hospital with a doctor and/or paramedic accompanying for ongoing treatment if required.

Staffing

- Staffing levels and skill mix were planned and reviewed appropriately to ensure patients received safe care and treatment at all times.
- The service employed and trained its own critical care paramedics (CCPs). Doctors were subcontracted from local NHS trusts, employed directly as contractors or released by the military to work in the service. The service paid the NHS for the doctors. The doctors worked a varying number of shifts (but a minimum of two shifts per calendar month to maintain competencies) and could also be seconded for up to a year to work for the service. From the rotas we looked at, there was always a doctor and one CCP on each shift. This meant that all missions were covered with the appropriate staff. The pilots were subcontracted from an aviation company. There was one pilot on each shift. They had received the appropriate induction and were experienced pilots.

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- We spoke with the base manager and the CCP who were responsible for the rotas, and they told us they had sufficient staff to enable them to roster the required number of staff for each shift.
- The service did use bank paramedics if needed. They had all been inducted to the service using the formal induction process. They would always be rostered onto the shift with either a doctor or full time critical care paramedic. This was not a regular occurrence.
- There were no formal scheduled breaks during a shift; however, staff said this was not an issue. The staff had enough 'down time' in between each mission. On average, the service had three missions per day.
- Staffing establishment was for 11 staff for the air ambulance and eight for the children's air ambulance. There were no vacancies at the time of the inspection.
- We observed the staff have a handover at the beginning of the shift. This included the doctor, critical care paramedic and the pilot. This included a safety briefing, aircraft, and equipment check. They would see on the data system what missions had been carried out on the previous shift.

Anticipated resource and capacity risks

- The service planned for any anticipated risk and these were outlined in the business continuity policy.
- Poor weather conditions posed a risk to delaying and disrupting missions. The service had access to a live electronic system, which provided updates about the weather forecast every 30 minutes. This was checked prior to each mission to ensure it was safe to fly. The pilot made the final decision. In the event they could not fly the aircraft, the team would be dispatched in a rapid response vehicle. The pilots told us it was rare weather to disrupt flights.
- The hospitals were alerted to an incoming patient once the crew had stabilised and transferred the patient into the aircraft. They had a list of all hospitals and which ones were major trauma centres. All staff knew the hospitals, and which specialised in specific areas, for example, cardiothoracic surgery, neurosurgery or had the right services for the patients with a stroke or myocardial infarction (heart attack). The service had not had any concerns with receiving hospitals not able to take their patients.
- There were processes in place in how to manage staff short-term sickness or emergency annual leave. This was outlined in their business continuity policy.

Response to major incidents

- Staff understood their roles in a major incident. The service had a standard operating procedure (SOP) for major incidents. The SOP outlined the services expected role in a major incident. It applied to major incidents affecting their tasking NHS ambulance trusts. There was a business continuity plan and policy that related to internal major incidents raised by the service.
- If the service was required to respond and support a major incident declared by the NHS ambulance services, there was a clear plan of initial actions, roles on scene, internal escalation and roles of off duty staff. The SOP went into further detail for specific incidents, for example, CRBN (chemical, biological, radiological, and nuclear incidents). The service's role regarding the media was also included. The SOP had been reviewed and changed in February 2017 and was due for review in 2019.
- All critical care paramedics received major incident training from The Joint Emergency Services Interoperability Programme (JESIP). This programme promotes joint working practices between emergency services at the scene of major incidents. The service was part of the NHS ambulance major incident planning and scenario training.
- The service had two doctors that had been involved in working in one of England's large terror attacks in 2017. They brought back their learning experiences and shared them with the whole service.
- The service had a response plan in case of an emergency situation with the aircraft, such as a crash or emergency landings due to a fault with aircraft. This was developed by the CAA, and all staff had access to this.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- The care and treatment of patients was based on nationally recognised guidance. These had been developed and tailored to meet the requirements of the aeromedical environment. This was due to the nature of the industry and the lack of specific guidance to support the treatment of specific conditions when airborne.
- There was a system in place to demonstrate that policies had been developed, reviewed, and updated to

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reflect current practice. The service policies were based on evidence-based guidance standards, best practice, and legislation. These included the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), the national Resuscitation Council, and the National Institute for Health and Care Excellence (NICE) guidance.

- We reviewed all policies in place for the service, including those for recruitment, medicines management, driving standards and debriefing policy. The policies had a date when first produced, a version number, and a date for next review. All policies had been reviewed within the outlined date.
- The service had a number of detailed and relevant standard operating procedures (SOPs), including clinical supervision, medical appraisal, and clinical guidance. These were all evidence based. Many of the doctors subcontracted to the service were contributors to journals and all were specialists in the field of pre-hospital emergency medicine (PHEM) and helped develop and review the policies and SOPs to keep them current. We saw a drive and passion in the clinical and senior management teams in providing the best clinical practice to their patients and leading the way in this field.
- Staff had access to all policies and SOPs. There was a system in place to give assurance to the senior management team to show that staff had read them.
- The staff had access to a clinical supervisors' group. This could be used to ask clinical questions. This group held teleconference meetings to discuss any new clinical update or changes in practice. This showed that they were always working to current best practice and treatment.
- The clinical staff audited their work in line with best practice. For example, they reviewed all cases when pre-hospital anaesthetic medicines were given to patients to ease the intubation procedure. Records of any invasive procedures, for example, amputation, or thoracotomies, were sent for external review by specialist in that field. The specialists had not needed to make any changes to their current practices in the last 18 months.
- Senior staff were aware of current evidence based guidance, standards and best practice was used to develop how their service, care and treatment was delivered.

Assessment and planning of care

- The assessment and planning of patients' care made sure they received the correct interventions to maintain their safety and wellbeing. Staff on missions had access to enhanced clinical advice and support. There was a clear timetable of senior clinicians to contact via text or telephone calls throughout their shifts.
- The service ensured that patients went to the most appropriate hospital in the most appropriate transport. They had a list of primary and secondary trauma care providers with information about the location of the helicopter-landing pad. They used a trauma tool to determine whether patients would benefit from a helicopter transfer to hospital. There was a clear SOP for this process.
- The service used appropriate technology and equipment to enhance the delivery of effective care and treatment. We heard how, while transporting the patient. The service sent pictures of injuries, for example burns, directly to the receiving consultant. This enabled them to prepare the team and equipment needed and if necessary provide any specialist advice.
- Clinical protocols were in place for the management of specific conditions, such as strokes and heart attacks. The protocols clearly identified the treatment pathways for children and adults.
- The service produced business cases for any additional equipment needed to enhance care and treatment. The senior management gave us an example of this. They had researched and made a case for a mechanical chest compression device in 2015. This helped treat patients who required prolonged cardiopulmonary resuscitation (CPR) in cases of drowning and hypothermia.

Response times and patient outcomes

- The service monitored compliance against its own key performance indicators (KPIs) to continue to drive improvements in patient outcomes. There was no mandatory requirement; however, the service had devised their own indicators to measure their own performance. These included procedural sedation and rapid sequence intubation (an airway management technique that produces immediate unresponsiveness and muscular relaxation, it is the fastest and most effective means of controlling the airway in a critically ill patient) and infection, prevention and control audits. This information was reviewed by the senior management team as it occurred, but also at the clinical governance committee meetings.

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- The service monitored its response times for each individual mission on a specifically designed data system. These times were monitored on a case-by-case basis with the head of operations, along with the requesting NHS ambulance trusts.
- The average response time, from the time the alert call came through from the requesting ambulance service, to the crew being on scene was 13 minutes. Due to the service being a solely charitable organisation, they did not have any contractual agreements with commissioners. Therefore, they were not required to formally record or submit response times. Despite this, the service maintained a record with details of the mission and any delayed take offs.
- The service worked with the national Trauma Network. The service could gain feedback from the regional Trauma Network regarding patient outcomes following a trauma. However, patient outcomes could not be formally monitored due to the specific nature of the service provided. The service provided trauma and emergency medical support to the NHS ambulance services. The patient was under the care of the NHS ambulance and NHS hospital service once treatment and transfer to a receiving hospital had taken place. The base manager attended regular meetings with the regional Trauma Network; if they were unavailable, they would send another staff member. We spoke with a member of staff from the regional Trauma Network and they gave very positive feedback for the service. They provided examples of where the service had learned from incidents and contributed into the wider learning in the trauma community. For example, after one incident was raised, the patient record forms were changed, to allow clinical staff to document a rationale for why they had chosen a particular treatment or medication. This made the hand over process to the receiving NHS hospital a safer process.
- The service held monthly morbidity and mortality meetings. We saw discussions of patients' care were recorded in detail. The clinical lead for the service attended these meetings. Staff said there was considerable learning gained through these meetings.
- We saw staff employment contracts, Disclose and Barring Service (DBS) checks, references, and work histories were all in place. The recruitment and selection process had been carried out to consider their competency for the role. This was in line with the recruitment policy.
- We saw staff had completed an induction programme and a competency process. New members of staff were clinically supervised by experienced critical care paramedics and pre-hospital emergency medicine trained doctors throughout their probationary/training period (during these missions they were supernumerary). Then they were supervised by the clinical lead to complete their clinical competencies. The induction process was detailed and rigorous and took three months. If it needed to be extended, it was, as not all competencies could be gained within this time if the mission did not include the staff to carry out a specific clinical skill.
- We saw staff discussing staff competencies during a shift. They were working with a newly appointed critical care paramedic (CCP) who had worked in another air ambulance service. They were planning which competencies were still needed to be fulfilled. All staff had a comprehensive competency booklet they had to complete. This was assessed at regular intervals to manage the progress of that member of staff.
- Staff showed enthusiasm for increasing their knowledge and skills through further training and development. They told us that they were encouraged and had the opportunities to do this within the service. They told us the service provided training in additional clinical skills and they felt that they received the required training to carry out their role effectively and to high clinical standards.
- Paramedics were critically care trained. They also had surgical skills training from an NHS teaching hospital. The service made this course mandatory for CCPs on a bi-annual basis to maintain competencies. Plans were in place for a local NHS teaching hospital to provide an anaesthetic and airway management course to the CCPs. This was not routinely offered to paramedics. However, due to the nature of the service's work it was deemed important to provide the CCPs with this extended clinical skill.
- The permanent clinical staff received monthly one to one meetings. Non-clinical staff received one to one meetings quarterly. These were then consolidated at the

Competent staff

- Staff had the skills, knowledge, and experience to deliver effective care and treatment. The service had systems in place to manage the effective staff recruitment process.

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end of the year in a performance and development review (PDR). We saw these had been completed for all clinical staff and were relevant and individual to the specific member of staff. The doctors received their appraisals through the NHS hospital they were employed at. The service kept a record of these.

- The clinical supervisor completed a review of their practice annually and provided feedback on a full range of practice, with areas of strength and areas for development with an action plan. This formed part of the appraisal.
- All CCPs had approved ambulance driving training. There was a driving policy, which outlined that emergency driving would be undertaken by the CCP working for the charity. A register of employees who were deemed competent to drive on emergencies was held by the head of operations. Refresher training had been developed to start in 2018, and every five years thereafter, to maintain their competency and the training carried out by a recognised 'blue light' driving trainer. The responsibility for ensuring the refresher training was completed was with the head of operations; however, this could be delegated to the base manager when required.
- The senior pilot ensured that all aviation training for clinical staff was carried out. This included training for new employees on induction and an intense course for the CCPs. They completed aviation navigation skills, and would be involved in selecting appropriate landing sites, alongside the pilot. The CCPs always sat in front with the pilot in the aircraft; hence, their training was more intense than the doctors. All staff that flew in the aircraft had to complete an annual check by the pilot. Although, there were no specific requirements for the doctors to complete this, they had the same assessment as the CCPs, as this was in line with best practice.
- Learning was shared through monthly team meetings and through a specific shared learning page on the services intranet. This was useful for staff who had been on annual leave or for doctors who had not worked recently. The e-learning system was available from home and they had protected training time during their shifts. Staff told us there were no issues with keeping up to date and completing their required training.

Coordination with other providers

- There were clear lines of responsibility and accountability for the service. Care was delivered in a coordinated way with all other services involved. We saw this working effectively whilst the staff were on a mission.
- There were agreed pathways with other providers and arrangements for escalating issues with the NHS ambulance trusts. Escalation went through the chief executives for matters relating to complaints and operational escalation was through the head of operations of each service, involving the base manager.
- The service had contracts in place with the requesting NHS ambulance services. They also had coordination arrangements with the local NHS hospitals, fire and rescue and police services. The head of operations or base manager attended 'Air Desk' meetings, with the NHS ambulance senior staff. Topics discussed were, operations, dispatch, training and staffing.
- All patients were transferred to the appropriate hospital depending on their medical need.

Multi-disciplinary working

- Effective and positive multi-disciplinary working was clearly evident. All necessary staff, including those in different teams and services, were involved in assessing, planning, and delivering people's care and treatment. The team told us they had effective communication with other services and teams of individuals they worked with.
- We did not see a handover between the air ambulance staff and the hospital during our inspection. However, we spoke with a consultant from one of the receiving hospitals and the feedback was positive. All handovers were delivered professionally and in a recognised clinical format for patients with traumatic injuries or medical emergencies.
- We saw evidence of the aviation and clinical team working closely together to during the flight and whilst on the scene. The team worked closely to coordinate their individual elements of the mission to enable the most direct, efficient and seamless service for the patient. We also saw excellent working relationships between the air ambulance crews and the NHS ambulance staff on scene.
- Staff told us it was important to work as a team between themselves, as well as with the land ambulance crews

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and other services such as, police and fire and rescue. This enabled them to overcome any challenges or obstacles to ensure the best service for the patient, both on the ground and when airborne.

Access to information

- Staff had access to relevant information when needed. The requesting NHS ambulance service had the access to information such as, do not attempt cardiopulmonary resuscitation forms (DNACPR) and advanced care plans. They carried out regular checks of these formal documents to make sure all information that was passed on to the air ambulance staff was relevant and up to date and to ensure that they were followed by staff.
- The requesting NHS ambulance service also notified the air ambulance crews if there were any know safeguarding children or vulnerable adult concerns.
- The rapid response vehicles had up to date satellite navigation systems in place and had been no incidents or concerns reported relating to these. The aircraft were all equipped with the appropriate navigation systems as advised by the Civil Aviation Authority.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). The service had a policy available for staff regarding capacity to consent. Staff demonstrated an effective understanding of the policy and understood how to make decisions in the best interests of patients.
- Staff told us that they asked for the patient's consent where possible. Due to the nature of the patients they attended, they were often unresponsive or trapped in vehicles. Then the patients' best interest and the staffs' duty of care was taken into consideration. Staff also had knowledge in gaining consent of patients under the age of 16. They could tell us about Gillick competence and how this related to their treatment of children, without a parent or guardian on scene.
- Staff were knowledgeable regarding the implications of the Mental Capacity Act 2005. They were able to describe how they would assess a patient's capacity to make decisions about their care and treatment and the best interest decision-making process.

- The patient record forms (PRFs) enabled staff to record whether the patient had capacity to consent.
- The staff all received MCA training: compliance for CCPs was 87%, including bank staff. The doctors could access the services e-learning MCA course: compliance showed 45% of doctors had completed the services course. When we asked the registered manager why compliance was only 45% for the doctors, they said this was because the other 55% had completed it as part of their NHS mandatory training. The doctor's personal files showed this.
- The service did not transport patients with a section 136 in place (an emergency power which allows people to be taken to place of safety from a public place if a police officer considered them to be suffering from a mental illness and need care), or who would need physical restraint. This was due to the safety of the staff and patient in the aircraft. However, care and treatment would still be provided on the scene.

Are emergency and urgent care services caring?

Compassionate care

- Care was provided in a sensitive and dignified way, wherever possible. The service provided critical care to patients involved in traumatic accidents and medical emergencies. Therefore, the patient was often in an unconscious state when they arrived: in these situations, they could not verbally communicate with the patient. We observed a mission where this was the case and despite the patient being unconscious, the critical care paramedic (CCP) and doctor maintained the patient's dignity at all times, whilst carrying out lifesaving treatment.
- Privacy and dignity was always protected in public places where possible. The CCPs and doctors would carry out their treatment in the back of a land ambulance if needed, until they were stable to be transferred to the aircraft.
- We observed that staff had caring attitudes and were respectful to patient's relatives or anyone else on scene.
- The doctor spoke with parents and relatives, if they were present at the scene, to explain the condition of the patient, and what the plan was. Any signs of deterioration were communicated effectively and compassionately.

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- The service displayed ‘thank you’ cards and letters sent by patients and relatives who used the service. They referred to their kindness and professionalism of the staff. Comments included; “your dedicated crew on site within minutes, they were kind, caring, and efficient to both my relative and me”. Other patients wrote; “I was treated like royalty and experienced a pain free flight”, and “thank you for the prompt and caring help you provided”.

Understanding and involvement of patients and those close to them

- During the inspection, we were not able to observe any missions where relatives, or people close to patients, were present.
- Staff kept patients and families well informed regarding the treatment taking place on the scene and the plan ahead, including which hospital they would be transferred to. The staff liaised with police on scene if needed, regarding them needing to contact and inform patient’s next of kin.
- Staff could not always take relatives to accompany the patient on flights. This was due to weight restrictions and limited space in the fuselage. Staff could take relatives where appropriate, especially if the patient was a child, they would always try and take a parent (as long as this did not impact on the flight or treatment that may be need to be carried out mid-flight). The pilot was accountable and made these decisions. If they deemed the relative or patient was not able to be transferred in a helicopter, they would arrange alternate transport for them, via the police service or land ambulance, or other transport. Staff explained to parents and relatives the reasons why and what the risks were.
- If a patient had capacity and was not undergoing life-saving treatment that needed to be transferred to a specific specialist hospital, the crew would take into account where the patient lived and which hospital was local to them. Staff gave an example of where this had occurred. A patient had fractured a limb, in an inaccessible area for a land ambulance. Therefore, the patient asked to be taken to a particular hospital near their home and not the closest one to where the incident occurred. The crew were able to accommodate this.

Emotional support

- We were not able to observe directly the staff providing emotional support during our inspection, due to the nature of the mission we accompanied them on.
- Staff we spoke with understood the impact that a person’s care, treatment, or condition would have on their well-being and those close to them, both physically and emotionally. They told us of examples where they had provided emotional support to relatives or people close to patient that had died and were on the scene. This was carried out in a supportive, kind, and unhurried manner. The staff told us of times where relatives had rung the service after a death or traumatic event, and they were happy to explain things further that they may not have understood at the time.

Are emergency and urgent care services responsive to people’s needs?

Service planning and delivery to meet the needs of local people

- The service effectively planned and delivered services based on patient needs. An example of this was the way the service was looking at how to provide and meet the trauma needs of their communities during the evening and night times. They worked closely with local NHS providers to develop a business case once they had decided what service would best meet this need. Staff looked at research and assessed flying the aircraft at night. This showed that the aircraft would have been ineffectual for a variety of operational reasons. Therefore, they put a business case forward for the use of rapid response vehicles. They used the same specialist clinical team to respond to traumas and medical emergencies during the night. This gave the NHS ambulance services an additional critical care resource and the public the same specialist clinical care, whether they had an accident or medical emergency during the day or night.
- The service worked closely with the requesting NHS ambulance services. They had regular ‘Air Desk’ meetings. The director of operations attended these meetings, with the NHS ambulance senior staff. The topics discussed were operations, dispatch, training, and staffing. Regular meetings were scheduled with NHS ambulance services to review incidents/trends and respond to their strategic requirements.

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- The service on average responded to six missions by helicopter a day. These were requested by a local NHS ambulance service. They were responded to in a sequential order. If they were on scene and needed to be dispatched to another incident before returning to base, this would be coordinated by the pilot and the critical care paramedic (CCP): they would take into account the fuel reserves on the aircraft and if any equipment needed replacing.
- The facilities and premises were appropriate for the services that were provided. The base was large and clean with appropriate storage areas. The hanger for the aircraft was appropriate and they were able to fuel the aircraft after each mission on their base.
- The service was planning to extend their critical care operating hours in 2018. The evening/night shift was 4pm until 2am. They had submitted a business case to extend this for 4pm to 7am. This had been identified as an unmet need, as no specialist trauma care was available between these hours, and informed how the service would plan and develop.
- The provider, The Air Ambulance Service (TAAS), was one of the first air ambulance Helicopter Emergency Medical Services (HEMS) providers in the country to fly with doctors on board, effectively bringing the emergency department to the patient's side. TAAS had continued to recruit and develop its future doctors for both helicopters and rapid response vehicles and was being registered with the Health Education England's West Midlands Deanery as a 'Local Education Provider' for pre-hospital emergency medicine trainees. TAAS was also committed to developing its critical care paramedic team with higher education and surgical practice opportunities to facilitate autonomous practice to improve clinical outcomes for patients.
- TAAS also provided the first and only dedicated helicopter aeromedical transfer service for critically ill children and babies (Children's Air Ambulance). The children's air ambulance was serving nine NHS specialist paediatric/neonatal transport teams across the country and was set to expand service further in 2018.
- TAAS was responsive to change to improve services to patients. This was evidenced by the significant investment being made to both the helicopter

emergency medical services and children's air ambulance services during 2018 with extended operating hours, new equipment, new aircraft all aimed at improving patient outcomes/experience.

Meeting people's individual needs

- Services were planned to take into account the different needs of the type of incidents and patients they responded to. This meant that specialist equipment such as the automatic cardio pulmonary resuscitation (CPR) machine and bariatric equipment was available.
- Given the acute response service provided, staff did not always know what specific individual needs of a patient they would be responding to. The requesting NHS ambulance service did not always have detailed information. However, staff had access to a telephone interpretation service through the NHS ambulance control room when needed, to facilitate the communication needs of patients that could not speak English. The CCPs also carried pictorial guides for use with patients living with dementia or a learning disability. Staff demonstrated an awareness of the needs of patients with vulnerabilities.
- The CCPs received training in dementia and mental health conditions. They would always risk assess, and take appropriate actions, when responding to a patient with a mental health illness. This was important due to putting the crew and patient at risk mid-flight.
- The service aimed to provide access to all in emergency critical care situations. However, due to it being an aeromedical service, there were certain patients they would not be able to transfer. These were heavy patients, due to weight restrictions, end of term pregnancy patients (this was classed as high risk if they gave birth during flight), patients with a known communicable infection, and patients with known chemical toxic poisoning, as they could not risk the pilot becoming contaminated during the flight. However, these patient groups would receive the treatment they needed on the scene and accompanied by a clinician from the service if they required on-going critical care support on-route to hospital in a land ambulance.

Access and flow

- Patients had access to timely care and critical care treatment. The requesting NHS ambulance service used a specific helicopter emergency medicine dispatch tool. They then made the alert call to the service. This was

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answered by the CCP, and at the same time, the pilot would go straight to the aircraft to start ignition and communicate with the control tower. The CCP and the doctor could then safely enter the aircraft, give the coordinates of the incident to the pilot, and start the take off at the same time. This procedure took approximately three minutes.

- Any delays, which resulted in a longer flight time, for example weather conditions, were communicated with the NHS ambulance service at the point of the alert call. The head of operations reviewed all calls in conjunction with the NHS ambulance service. The service had a direct electronic link to the NHS ambulance service: this showed them the status of the aircraft, whether it was 'online' and ready for flight.
- 'On scene' turnaround times and response times were not measured by the service, as this was not a requirement. The service did review its own response times. The average response time from the alert call to arrival on scene was 13 minutes.

Learning from complaints and concerns

- Effective procedures were in place to respond and learn from complaints. People who used the service were aware of how to make a complaint or raise a concern. The service advised patients of how to make a complaint: this was done through their website. We saw that this was easy to navigate and use. Patients could also complain to the NHS ambulance service or hospital and the service could receive complaint via this route.
- A complaints policy was in place dated for review in 2019. This outlined the time frame for complaints to be acknowledged to which was three days, then there was a time frame of 25 working days for the service to carry out the investigation and provide a formal response.
- Staff were aware of the complaints process, and had read the complaints policy. They told us they would receive feedback when a complaint was made and said that all complaints were investigated thoroughly. Learning opportunities would be discussed at team meetings.
- The service had received one complaint from January 2016 to December 2017. We saw a detailed investigation and response to the complainant within the required period.
- If the complaint required it, the service would work collaboratively with the relevant NHS ambulance service.

- The service did not benchmark complaints against other providers. This was due to the low number of complaints received.
- We were told that the service had received 20 compliments from January 2017 to October 2017.

Are emergency and urgent care services well-led?

Leadership of service

- Leaders had the skills, knowledge, experience, and integrity they needed to ensure the service met patient needs. The director of operations led the service; they were also the registered manager. The head of operations oversaw the organisational arrangements at the individual airbases. Both of the airbases had a site manager. There was also a clinical lead and two deputy clinical leads who were experienced doctors.
- The director of operations had Prince II (project management) skills, and other senior managers demonstrated a high level of strategic planning and people management skills. The clinical leads all held relevant trauma and pre-hospital emergency medicine qualifications.
- Leaders understood the challenges to good quality care in their service. They told us these included the timeliness of tasking, stand down rates, management capacity for expanding the service, developing dashboards and databases, and improving patient follow up.
- Leaders on both sites were visible and approachable. This was confirmed by all staff we spoke with. They knew what their leaders were responsible and accountable for. The deputy clinical lead told us they felt supported by the operational leaders and the executive board and their clinical expertise was respected and acknowledged.
- In addition to their clinical paramedic duties, the critical care paramedics (CCPs) held other organisational roles, such as, roster management and procurement of supplies and equipment.
- The service did not have a Freedom to Speak Up champion, as the service was not an NHS provider. However, the director of operations told us that they had an open culture and any concerns that were raised by staff were responded to in the spirit of openness and candour. If staff did not want to speak to a member of

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leadership team, they could raise issues with the local NHS ambulance services or other members of the charity's senior leadership team. Staff said that they had not needed these routes of escalation.

Vision and strategy

- The service had a clear vision and strategy, underpinned by holistic values that were embraced by all staff.
- The service's mission statement was to:
- 'Save lives and improve patient outcomes by providing a rapid response to trauma and medical emergencies.'
- 'To be free of charge to patient and to the NHS.'
- 'To provide services whenever and wherever we can.'
- There was a detailed strategy for achieving strategic aims and priorities, with clinical quality and safety the top priorities. These were outlined in the charity's strategic plan 2015 to 2020. The first strategic aim was to: 'continuously advance rapid response critical care services to patients.' This was translated into an annual operational strategy, supported by implementation plans, which focused on continuously upgrading rapid response provision, and a three-year air ambulance clinical strategy. The clinical strategy focused on training, key performance indicators, audit, equipment, research, and recruitment. These strategies were supported by clear action plans that were monitored by leaders.
- The service was clear on its priorities for 2018, which included extending the operating hours for critical care rapid response vehicles, expanding the children's air ambulance service, evaluating the use of pre-hospital ultrasound, developing a cardiac care strategy with NHS ambulance services and carrying out clinical research.
- The service allocated resources to match its aim of continuously advancing rapid response critical care, showing that quality and safety were the top priority. Managers and clinicians explained how the service always funded clinical needs such as specialist training or equipment. Funding was prioritised by looking at how best plans would benefit the patient. Learning was budgeted for separately so the service was able to prioritise developing a high level of clinical skills.
- The service's vision was 'We want children to grow into adults, we want adults to live longer, and we want bereavement through trauma to become rare.'

- The service's values were 'compassion, courage, and creativity.' The vision, values, and strategy were developed with partner organisations, such as the NHS ambulance service.
- All staff demonstrated the values fully. We observed staff on emergency missions and they showed by their passion and commitment to the work and to the organisational values.
- Staff also knew and understood the strategy and their role in achieving it. The service held quarterly strategy meetings, which could include staff at all levels. Twice a year the clinical team attended. Staff and managers monitored and reviewed progress against the strategy at these meetings, giving them a clear understanding of the vision and strategy.
- These strategy meetings resulted in some changes to implementation plans, which were reviewed at operational team monthly meetings. For example, in response to a pilot's suggestion to look at the feasibility of night flying, they researched the business case for this. They involved the tasking NHS ambulance services. The business case concluded that rapid response vehicles were the best option for night shift response.

Governance, risk management, and quality measurement

- There was an effective governance framework to support good quality care. The service held regular senior management team meetings, which monitored progress on achieving strategic aims. Monthly operational group meetings monitored progress on the operational strategy. The director of operations fed any information from the front line level, such as achievements or incidents, to the senior management team meetings. This was then fed from the meeting to the operational group.
- The clinical governance group held meetings quarterly. They had clear terms of reference, which included reviewing the operational risk register, monitoring the clinical governance work plan, reviewing national clinical guidance, and shared learning. Managers and clinical leads also reviewed clinical learning at morbidity and mortality meetings, which were held monthly at alternate airbases. This ensured that clinical practice continuously improved.
- There were a range of policies and standard operating procedures which underpinned the governance structure. This was supported by a red/green

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monitoring system which showed who had read and who had yet to read the standard operating procedure or policy update. The service introduced new procedures to reflect good practice and national guidance. During our inspection, the service was implementing a new protocol for spinal injuries.

- Policies were reviewed every two years and covered key issues such as raising and responding to concerns, adverse incident investigation, complaints, driving policy, consent, medicines management, management of controlled drugs, medicines' management and infection prevention and control. This ensured patient safety as much as possible, and promoted a consistency of approach in day-to-day working.
- The service actively reviewed their risk register, which was comprehensive, at the clinical governance group and operational management group. There was a clinical risk register and an organisational risk register. This included risks such as poor dispatch decision making, use of non-approved equipment, and failure to maintain paramedic cover. The grading system of the risks matched that of the NHS ambulance service. They took action to mitigate risks, and formulated clear action plans that were taken to the board.
- Managers reviewed risks monthly and reported them to the senior management team. They supplied an action plan to mitigate each risk and this included actions, such as, developing a doctor recruitment plan to ensure doctor cover on all shifts. There were monthly risk register meetings and risks were reported to the senior management team monthly, then to the board on a quarterly basis. This ensured senior management and trustee oversight.
- The service had clear working arrangements with partners. They based service delivery for both the air ambulance locations, on a service level agreement developed with local NHS ambulance providers. The service level agreement was reviewed every six months. Local NHS ambulance providers informed us the director and head of operations attended weekly and monthly meetings with them, and spoke highly of the service. The local NHS ambulance service boards also monitored activity reports from the service.
- Clinical staff were clear about their roles and what they were accountable for. They completed a self-assessment for their annual appraisal process. Two sets of competencies were measured: behavioural and

professional. Each team had defined competencies for their roles. Personal objectives were clearly linked to strategic objectives, ensuring a focused approach throughout the organisation.

- The service was continuously improving the personal development and review (PDR) process. From the 2017 audit of the process, they modified the structure of PDRs, to make them user friendly and formed the basis for an annual review of responsibilities. We reviewed staff files and found that appraisals were complete and up to date. Clinicians we spoke with found their one-to-one meetings very useful.
- There was a programme of clinical audits linked to training. PHEM (pre hospital emergency medicine) trainee doctors completed emergency medicines audits, and the clinical leads audited work at both airbases.
- Quality and performance monitoring arrangements were in development. Service activity levels and stand downs with staffing level information was reported at trustee board level. They used this information to solve operational issues such as night cover, or when shifts had ran without a doctor. The service lacked a dashboard to monitor response times, clinical outcomes and other quality indicators. They reviewed response times with the local NHS ambulance providers (tasking agents) and some clinical indicators were monitored at clinical governance group.
- Leaders were proud of the governance and quality standards for both the helicopter emergency medical services and children's air ambulance services and operated an open door policy for NHS stakeholders to inspect their services at any time. The most recent independent inspection was undertaken in October 2017, by one of the children's air ambulance clinical partners by the 'Commission on Accreditation of Medical Transport Systems'. Feedback was very positive.

Culture within the service

- The service had an open and learning culture, fully focused on safe and high quality patient care. Clinicians worked with a mutual respect, candour, and honesty. The same staff worked across the two air ambulance services, at both airbases, and this ensured a consistency of approach.
- Staff turnover was low and staff sickness compared favourably with the NHS ambulance services. In October 2017, November 2017 and December 2017 respectively,

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1.9%, 3.8% and 1.9% of operational staff took sickness absence. In the NHS ambulance services, the latest available statistics showed that from July to September 2017, showed a provisional absence figure of 4%.

- Staff shared learning through monthly team meetings and through the services intranet learning pages. The service was also developing a shared learning platform for doctors.
- The learning culture was supported by learning events. One of the quarterly strategy review meetings was also a learning conference. All staff were invited from across the charity and up to 300 people attended. All staff participated in a 'skills swap' to gain a better understanding of the wider charity.
- The service managed organisational change through a project management approach but also through bringing in experts such as procurement consultants for one-off projects.
- The organisational culture promoted staff wellbeing. Colleagues or managers debriefed clinicians after their missions and we saw evidence of peer support. The last staff survey identified that the service needed to do more to support staff wellbeing. The service responded by working with a mental health charity on a programme to help blue light emergency staff to manage stress and mental health. The service had a contract with an occupational health company to provide private counselling and psychological support to staff, in response to the staff survey. This was outlined in the debrief policy.
- During the inspection, staff told us that they felt well supported in their role and the service was effective in debriefing staff. They told us they felt able to challenge practice and a member of staff said they had done this in the past. They said, "There is no fear in challenging practice, as this leads to productive discussions to discuss alternative options". Another member of staff described the culture as 'nurturing', but the link between headquarters and the operational staff could be stronger. The senior managers told us this was due to headquarters located in a different location, but would feed this back to the trust board.

Public and staff engagement

- Staff and public engagement was positive and designed to seek feedback to continue to improve the service. The 2017 annual staff survey showed a high level of job satisfaction within the service. Although it was unclear

how many respondents were clinicians, the survey had a 79% response rate, and 98% of respondents believed the charity set the standard of excellence in patient care and 97% of respondents were proud to work for the charity.

- Staff were engaged in strategic working through the quarterly conferences. These meetings included a question and answer session, so that everyone could ask senior management questions if they wished. The quarterly conferences were also a mechanism for recognising staff achievements, there was an award ceremony at the Christmas conference.
- Staff were very positive about the level of their involvement in decision making and said they felt their views were sought after and listened to. Staff felt engaged with the service and said they were encouraged to look at ways of improving.
- Clinical staff participated in public events where possible, to raise the profile of the service. Some of the staff, including the base managers, were involved with fund raising for the charity. All the staff we met were passionate about the charity and providing care for patients.
- The service had very positive public feedback. We saw many thank you cards posted on the walls of the airbase, which grateful patients and relatives had sent to the service. Owing to the nature of the service, it was difficult to obtain patient feedback at the time of the emergency. Instead, clinicians invited patients to feedback through the air ambulance website.

Innovation, improvement, and sustainability

- The service had developed an innovative system of recruiting its own paramedics and offering them a high level of pre-hospital emergency care training, with a local university. The critical care paramedics were employed directly by the service and said they benefited from a high level of ongoing skills development.
- The service held joint pre-hospital emergency medicine study days with other organisations.
- Staff told us they were encouraged to identify improvements for the service and their suggestion were considered. For example, the service was assessing the potential benefits of carrying portable ultrasound equipment and a video laryngoscope.

Emergency and urgent care services

- Staff were engaged in the development of the aircraft and helped support any changes of new equipment. There was a “proposed change” form for this initiative. These were then submitted to the clinical leads and fed into the clinical governance committee meetings.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Review processes for maintaining safeguarding policies in line with national legislation and guidance.
- Consider formal safeguarding training for pilots.