Air Alliance Medflight UK Limited

Air Alliance Medflight UK

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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Air Alliance is operated by Air Alliance Medflight UK Limited. The service provides a planned and emergency patient transport service for adults and children abroad.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 3 July 2018.

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

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

Services we do not rate

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

We found the following areas of good practice:

- There was a good incident reporting culture which resulted in improvements in practice.
- Staff were up to date with mandatory training, all of which had evidence of reviews and updates. Staff had completed safeguarding children and adults training to the required level. The registered manager was trained to a level 4 qualification in safeguarding adults and children.
- There was a strong focus on infection prevention and control measures to ensure ongoing compliance, including regular audit.
- The equipment and environment used by the provider were appropriate and well maintained. There were effective systems to ensure ongoing safety.
- Staffing levels were appropriate to meet the needs of the patients. There were sufficient numbers of qualified staff on the sub-contractors register.
- Patients records were complete and up to date and accessible to those that needed them.
- There were safe medicines management policies/processes/practices which included a service level agreement with a local NHS trust for supply and audit.
- Patients had their nutrition and hydration needs met and staff used evidence based risk screening tools to assess and manage risks.
- The service operated a 24-hour, seven-day week service with operational staff who were multi-lingual carrying out assessments.
- Staff were employed based on their competency to ensure they were skilled to meet the needs of the individual patients. Staff were multi-disciplinary and worked well together to provide good quality care.
- People provided feedback about the care they received. The feedback about staff was overwhelming positive, for example staff were described as caring and experiences were good.

Summary of findings

- The service met people's individual needs. For example, they sourced aeroplanes that were the right size to accommodate patients with families. They had accessible translation services to communicate with patients using their own language. Staff were from diverse backgrounds and when assessing a job, staff could be employed based on their cultural or religious background, for example, employing a Muslim team member if that was a patient's preference.
- The leadership and staff team were highly qualified. There were effective governance systems to ensure oversight and standards were being met.
- Staff worked alongside accredited bodies, were involved with other regulatory bodies and were involved in research.

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

- Sub-contracted patient transport services on the ground did not always have all the relevant checks in place to assure the provider that vehicles had up to date insurance certificates.
- Patient outcomes were not routinely monitored.
- The provider was in the process of writing a business strategy, however it was not available at the time of inspection.
- Documentation to confirm staff competency was not checked and verified by an experienced member of staff.
- Managers did not have a system in place to document and review annual appraisals and supervision.

Heidi Smoult

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services		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: • There was a good incident reporting culture which resulted in improvements in practice. • Staff were up to date with mandatory training, all of which had evidence of reviews and updates. Staff had completed safeguarding children and adults training to the required level. The registered manager was trained to a level four qualification in safeguarding adults and children. • There was a strong focus on infection prevention and control measures to ensure ongoing compliance, including regular audit. • The equipment and environment used by the provider were appropriate and well maintained. There were effective systems to ensure ongoing safety. • Staffing levels were appropriate to meet the needs of the patients. There were sufficient numbers of qualified staff on the sub-contractors register. • Patients records were complete and up to date and accessible to those that needed them. • There were safe medicines management policies/ processes/practices which included a service level agreement with a local NHS trust for supply and audit. • Patients had their nutrition and hydration needs met and staff used evidence based risk screening tools to assess and manage risks. • The service operated a 24-hour, seven day week service with operational staff who were multi-lingual carrying out assessments.

Summary of findings

- Staff were employed based on their competency to ensure they were skilled to meet the needs of the individual patients. Staff were multi-disciplinary and worked well together to provide good quality care.
- People provided feedback about the care they received. The feedback about staff was overwhelming positive, for example staff were described as caring and experiences were good.
- The service met people's individual needs. For example, they sourced aeroplanes that were the right size to accommodate patients with families. They had accessible translation services to communicate with patients using their own language. Staff were from diverse backgrounds and when assessing a job, staff could be employed based their cultural or religious background, for example, employing a Muslim team member if that was a patient's preference.
- The leadership and staff team were highly qualified. There were effective governance systems to ensure oversight and standards were being met.
- Staff worked alongside accredited bodies, were involved with other regulatory bodies and were involved in research.

However,

- Sub-contracted patient transport services on the ground did not always have all the relevant checks in place to assure the provider that vehicles had up to date insurance certificates.
- Patient outcomes were not routinely monitored and there was no system to record outcomes.
- The provider was in the process of writing a business strategy, however it was not available at the time of inspection.
- Documentation to confirm staff competency was not checked and verified by an experienced member of staff.
- Managers did not have a system in place to document and review annual appraisals and supervision.

Air Alliance Medflight UK

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Background to Air Alliance Medflight UK

Air Alliance is operated by Air Alliance Medflight UK Limited. The service opened in 2016. It is an independent air ambulance service based at Birmingham Airport.

They are a 24/7 multilingual operation and leader in aircraft technology. They employ 150 staff pool of senior doctors and nurses on an adhoc basis. They are accredited by the European Aeromedical Institute and Commission on Accreditation and carry out over 950 air ambulance missions per year. For their paediatric and neonatal services they have 14 of their own aircraft based across Germany, Austria and UK. The service has had a registered manager in post since 2016.

The aircraft are a combination of short, mid and long range. The configurations are two to three stretchers. The long-range aircraft can accommodate up to 10 people. Air Alliance Medflight has a team of health workers on standby to help in case of emergency: using aircraft with medical equipment to transfer patients quickly and reliably to the desired hospital. The repartition service includes collecting patient anywhere in the world and cared for them until the handover at the destination hospital. Whether dealing with accident victims who require monitoring or critically ill intensive care patients, complex transport requirements can also be met.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Air Alliance Medflight UK Limited provides repatriation services to patients who have privately funded (or part privately funded) and this is regulated by CQC. However, they also provide treatment under arrangements of an insurance policy not primarily or solely intended for diagnosis and treatment (e.g. travel insurance), which is exempt by law from CQC regulation. CQC's remit is also limited to services provided within England. Air Alliance were unable to record for each patient how their treatment was funded, but were able to confirm that the same process, policies and procedures are in place for all patients.

The service is registered to provide the following regulated activities:

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

While on inspection we spoke with the chief flight nurse who has a background in critical care and is the infection prevention control lead. We spoke with the registered manager, who is a registered nurse with a background in critical care, the director for the UK with a background in flight crew, the medical director, a consultant anaesthetist/intensivist, who had clinical oversight, a paramedic and senior flight nurse.

During the inspection, we visited the UK base at Birmingham Airport. We spoke with six members of staff

Detailed findings

including; a registered paramedic, a medical director, the registered manager, the general manager and two senior nurses, all staff we spoke with also worked within the NHS.

During our inspection, we reviewed nine sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity from 2 January 2018 to 21 May 2018 was 131 flights from various destinations.

The staff were registered paramedics and nurses, consultants, general managers, and a bank of subcontracted staff that could be utilised by the provider. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- There were no never events
- There were no clinical incidents that met the threshold for CQC notification.
- There were no reportable serious injuries.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an additional CQC inspector and a specialist advisor with expertise in urgent and emergency patient transport services. The inspection team was overseen by Victoria Watkins, Head of Hospital Inspection.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings

We found the following areas of good practice:

- There was a good incident reporting culture with improvements made to practice as a result.
- Staff were up to date with mandatory training, all had evidence of reviews and updates. Staff were trained to safeguard children and adults. The registered manager was trained to a level four qualification in safeguarding for adult and children.
- There was a strong focus on infection prevention and control with measures to ensure ongoing compliance, including regular audit and improvements as a result.
- The equipment and environment used by the provider was appropriate and well maintained. There were effective systems to ensure ongoing safety.
- Staffing levels were appropriate to meet the needs of the patients. There were sufficient numbers of qualified staff on the sub-contractors register.
- Patients records were complete and up to date and accessible to those that needed them. There were good medicines management policies/procedures/ practices, including a service level agreement with a local NHS trust for supply and audit.
- Patients received evidence based care and there were policies and procedures aligned with evidence based guidance to support good quality care. Patient's had their nutrition and hydration needs met and staff used evidence based risk screening tools to assess and manage risks.

Emergency and urgent care services

- The central referral service were based in Germany, they operated a 24-hour, seven day a week service with operational staff who were multilingual carrying out assessments.
- Staff were employed based on their competency, to ensure they were skilled to meet the needs of the individual patients. Staff were multi-disciplinary and worked well together to provide good quality care.
- People provided feedback about the care they received. The feedback about staff was overwhelming positive, for example staff were described as caring and experiences were good.
- The service was set up to meet people's individual needs. For example, they could source aeroplanes of the right size to accommodate patients with families. They had accessible translation services in the form of a mobile phone application to communicate with patients using their own language. Staff were from diverse backgrounds and when assessing a job, staff could book staff based on cultural or religious preferences, for example, employing a Muslim team member if that was a patient's preference.
- The leadership and staff team were highly qualified. There were effective governance systems to ensure oversight and standards were being met.
- Staff worked alongside accredited bodies, were involved with other regulatory bodies and were involved in research.

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

- Sub-contracted patient transport services on the ground did not always have all the relevant checks in place to assure themselves that vehicles had up to date insurance certificates.
- Patient outcomes were not routinely monitored and there was no system to do so.
- The provider was in the process of writing a strategy, however it was not available at the time of inspection.
- Staff competencies were observed, however, there was no related documentation to confirm staff competency was not checked and verified by an experienced member of staff.
- There was not a system in place to document and review annual appraisals and supervision for subcontracted staff.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- Staff were trained to identify and report incidents and we saw documented evidence of incident reporting. Staff used a paper based system to record incidents. Each flight crew carried a pack of documentation which included an incident report form. This meant that staff had access to the documentation which they could complete at each flight if required.
- In the event of an incident, staff completed the documentation, this was followed up by a review from a manager. Where appropriate, this would be followed by a root cause analysis carried out by the registered manager who was suitably trained. We saw evidence of recording of incidents over the previous 12 months. The incidents were assessed using a severity and likelihood matrix. Learning points were discussed at clinical governance meetings and then disseminated to staff using a communication book that had to be signed to evidence staff had read and understood the content.
- We looked at six months of governance meeting minutes and saw incidents were discussed as standard at each meeting. We saw evidence of improvements in practice as a result of incident reporting. For example, a pre-flight briefing form was introduced for crews to ensure they carried all the necessary equipment to deliver treatment.
- We asked the leadership team about how safety performance compared with other similar services. They told us that this was very difficult to do because they were a specialist service. They had looked at national accreditation data, however it was not always relevant and they could not benchmark or measure against the data. This was made difficult because data was commercial and sharing between companies did not happen.
- We saw that there were specific considerations to the service within England. For example, staff knew and understood duty of candour. Every healthcare professional must be 'open' and 'honest' with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress, apologise to the patient (or, where appropriate, the patient's advocate, carer or family). Medical teams referred all duty of candour issues to a medical director to ensure each case was addressed. Senior staff met monthly and a medical director attended a quarterly meeting where duty of candour could be discussed. There had been no deaths or incidents that required duty of candour processes to be followed.

Mandatory training

- Any training completed by staff employed by the NHS was accepted and staff were expected to share their training certificates with the provider. The service mandatory training requirements were outlined in policy. All staff were a minimum level two safeguarding adults and children, Mental Capacity Act 2005 training, infection prevention and control and immediate or advanced life support this included paediatric life support.
- There was a system to ensure all staff had the minimum mandatory required training which was evidenced with certificates. We looked at the provider's training matrix which highlighted all staff had up-to-date mandatory training. We looked at four staff files and each contained up-to-date certificates that met the minimum mandatory service requirements. This meant there was an effective assurance system to ensure staff had the required minimum training to fulfil the requirements of the role.
- Managers had access to a database to check expiry dates. The system prompted renewed and updated evidence of certificates. If people could not provide evidence of up-to-date training they were taken off the flight rota. They then had to reapply for their positions and go through the recruitment process again. We saw this evidenced in staff files and in the database kept by managers.
- All flight staff were appropriately trained and qualified with mandatory training completed and on file. Some of the medical staff, for example, the medical director was also a qualified pilot. This meant that there were substantive staff who were qualified to fly the aircraft as well as those subcontracted.

Safeguarding

- All staff had completed safeguarding adults and children training. We saw evidence on the training matrix and in staff files of training completed at level two and level three safeguarding adults and children. The registered manager was trained to a level four for both children and adult. This is in line with the intercollegiate guidance.
- There were safeguarding systems, processes and practices developed, implemented and communicated to staff. We looked at safeguarding posters shared with staff which clearly highlighted the process for sharing safeguarding information, who to contact and how to contact them. Staff we spoke with could provide us with examples of when they had identified a concern and the steps they took to do ensure the patients ongoing wellbeing. This meant staff were appropriately trained in safeguarding, knew who and how to contact when there were identified safeguarding concerns.
- The safeguarding lead had completed the level four safeguarding training for both children and adults in 2018. They gave us an example of what they had learned from the higher-level training and what they would now do differently. For example, prior to training they had identified a safeguarding concern and raised this with the receiving hospital. Since completing the level four training, they advised they would manage the incident differently. They would make a direct safeguarding referral to the local safeguarding team. This meant they had a better understanding of safeguarding processes since completing a higher-level qualification. Staff we spoke with knew about this incident and had shared the learning from it to improve their understanding.

Cleanliness, infection control and hygiene

- There was an infection prevention and control lead and an externally validated policy with an aligned audit protocol to monitor that the policy was followed. The recognised external validator provided suggestions for improvements and assurances about the effectiveness of procedures. This meant that their policy and procedures were effective and in line with national guidance.
- There were monthly reviews of documentation to ensure the policy was followed. Staff carried out spot checks of documentation to ensure compliance. In addition, there was cleaning and fogging of the aircraft at least weekly which included disinsection. This was where staff shut the aircraft door, sprayed insecticide to reduce the incidence of bugs that might carry risks, for example, malaria. Staff were kept aware of local diseases that could be brought on to the aircraft.
- An external provider was employed to deep clean each aircraft before and after each flight. This was required to prevent and control infections. For example, they carried out a deep clean fog for MRSA. Each clean was documented and infection notes completed to relay specific response that had to be dealt with. Staff used specialist equipment to measure cleaning efficiency. The instruments used were evidence based tools to measure effectiveness of surface cleaning and disinfection in healthcare settings. Care was taken particularly in the main patient contact areas including cockpit. Staff cleaning the aircraft were not permitted to touch anything in the cockpit and therefore relied on steam clean only. All products used were aviation safe assured.
- The aircraft we inspected was visibly clean, equipment were cleaned after each usage, we saw document to support this.
- The leadership team kept up to date with worldwide infections using approved websites when they travelled to, and within, high risk areas. Staff who were suitably knowledgeable and skilled were employed to ensure they were competent to assess and manage communicable diseases that might be anticipated from a country. For example, countries were there had been Ebola risks. This meant they were assured competent staff were on board to deal with potential concerns specific to that country.
- Staff emptied clinical and general waste into an appropriately sized locked container each day. Air Alliance had an agreement with a local trust for disposal of any clinical waste such as sharps bins. This meant waste was disposed of using an approved provider.
- All staff were registered professionals who worked substantively in healthcare settings. This meant that they had a level of training with annual infection prevention updates from their NHS role. We saw this evidenced in a training matrix and in staff files. Staff had local induction updates which were audited.

- Infection prevention and control was discussed and recorded at clinical governance meetings. For example, at each meeting we saw references to policies, training, and addressing concerns related to preventing the spread of infections. Staff kept up to date by looking at a communication folder which had to be signed to confirm staff had read the most up to date information. Staff used a closed group social media to transmit updates and there was a clinical folder to be read on the aircraft.
- Staff ensured standards of cleanliness were maintained by carrying out monthly infection control audits relating to the environment, hand hygiene and personal protective equipment. We looked at recorded audits and saw that from March 2018, each month the audits were at 90% compliance which met their target.

Environment and equipment

- Equipment and aeroplanes were maintained according to manufacturer's instructions. The aeroplanes were kept in a locked warehouse at the main provider site. Staff were required to attend the main office to collect their identity badge and sign out for the day. Before taking out the aeroplane out on transfer, each crew member and pilot carried out flight worthiness checks to ensure safety measures were in place.
  Air Alliance had medical equipment on board, some equipment for monitoring, diagnosis and therapy as well as back-up devices. This included non-invasive and invasive pressure monitoring (blood pressure, central venous pressure, cerebral pressure, tissue compartment pressure). They had assisted spontaneous and controlled ventilation of intubated and non-intubated patients. Ventilatory adjustments were governed by portable blood gas analysis. Large oxygen tanks on-board the aircrafts enabled ventilation, even with high inspiratory oxygen concentrations. The permanently installed double-stretcher allowed transport of two patients if medically acceptable. On the Challenger 604, up to three stretchers could be installed.
- Staff could access oxygen and nitrous oxide cylinders in suitable secure locked rooms at the warehouse. On the aeroplane these were kept in a secured designated area in the back of the plane. Empty and full cylinders were kept separate and were easily identified. Air Alliance had a contract with an approved third party for delivery and pick up of cylinders. This meant they were accessible, securely stored and disposed of appropriately.
- We were unable to review the equipment kit as both kits were out on flight transfer, however we saw staff carried out a weekly checklist for stock, and daily check out and check in equipment log. Staff told us that medical staff were responsible for the checking in and out of the equipment and to ensure all stock was replaced in each equipment bag.
- Staff told us that each equipment bag was sealed with a tag and a serial number. When they checked out an equipment bag they always checked the tag was sealed and recorded the serial number and expiry date. We saw this recorded to ensure the kits were safe to use.
- The chief nurse told us that they were waiting for three new equipment kits. These kits were lighter to carry and more electronically efficient. The deadline for full implementation was August 2018. There were processes to ensure replacement of equipment and consumables. There were also processes to reseal, check and replenish equipment and consumables and there were checklists in every bag.
- Arrangements were in place for the clinical engineering company to contact Air Alliance when equipment servicing was due. There was an equipment specification record in place. The record contained details of what equipment staff kept in each equipment bag.
- We checked the restraints on the stretchers on one aeroplane and found them to be in good condition. The stretchers on the aeroplane could transport patients up to 130kg depending on the specification on the aeroplane.
- Staff demonstrated they had three different extendable seat belts for children all depending on weight and height of the child. We were also told by staff that they have an incubator pod that could replace a stretcher on a flight transfer if needed. This meant the needs of children were considered and equipment was available to meet their needs.

- Staff told us and we saw that they provided patients with an additional air mattress such as 'vac' mattress specific for spinal patients and those patients on long-haul flights. This was to ensure patients' pressure areas were relieved as much as possible.
- Patients were transferred from the airport to their agreed destination using a sub-contracted patient transport services. We looked at the patient transport service records to ensure all the checks were in place, for example, insurance was up to date and saw that these checks were incomplete for one regular subcontractor ground patient transport service. One manager told us that this was a piece of work that they needed to do to improve their checks with patient transport services on the ground.

Assessing and responding to patient risk

- Patient information could be limited at referral stage, however, staff carried out a bedside assessment in addition to the information received. Staff worked closely with the leadership team to ensure that each flight was well planned. The process of transporting patients from a range of other countries brought with it varying complex issues that could have an impact on the safety and wellbeing of patients.
- Staff used an integrated web-based quality and risk management system for aviation this was implemented in 2018. The flight crew were fully trained; however, the medical crew training had been planned for roll out the week following this inspection. Trained staff were in a position to support medical staff during flights in accessing information if needed.
- The electronic system meant staff could log in and review patient online reports and risk assessments. When fully implemented, staff would have a phone app to access patient information and to submit reports while mobile. This meant all information relating to patient transfers could be managed while trained staff were on the go and at any time.
- Staff could access patient transport pre-flight and post-flight briefing documentation. This included a checklist to confirm staff were well rested, fit to go, maintenance issues, equipment safety and diversions possibilities. The leadership team told us diversions were a rarity, however, the pilot always planned for it. This meant there were robust systems in place to check for safety.
- Staff told us assessing and managing risk was an ongoing consideration. Staff provided us with numerous examples of some of the complex issues they had to consider. For example, cases where flights had to be diverted. Staff considered in advance, countries they were flying over and if expert care was accessible if a diversion was necessary. For example, they would consider if they needed blood or neurosurgery expertise. These considerations would be assessed in advance of each journey and were based on the patient's individual needs as well as which country they would be travelling to and from.
- Staff used National Early Warning Scores (NEWS) which monitors patients' physiological presentations such as pulse, temperatures and respiration to ascertain if they are at risk of their health deteriorating. We reviewed four patient records and found NEWS was completed correctly. All patients' vital signs were taken before any transfer as a baseline observation. Staff told us any concerns would be considered to determine whether a patient was fit for transfer. Staff told us they monitored any patients they were transporting closely for any changes in condition and ensured they took observations regularly so they could share information with the admitting hospital.
- Staff gave us an example of when a patient who was well on take-off, had deteriorated mid- flight and how they managed it. There was an anaesthetist and senior nurse on board the flight. They discussed the deteriorating patient to review options and used an inflight phone to call directly to the on-call clinical co-ordinator for an independent view. Changes in the patient's clinical presentation meant changes might be needed to ongoing care arrangements. If the patient required a greater level of care this meant the hospital might have to find specialist beds or care facilities.
- Staff used a client risk assessment matrix to assess patients' needs. Each patient received a red, amber or green rating, which related to what medical coordinators had to consider to keep patients safe. Some clients had a reputation for not providing all the information needed to safely assess the patient's needs.

The leadership team told us they sometimes refused or deferred jobs as a result and we were given examples. Referrals are accepted on the basis that there is very little risk of deterioration.

Staffing

- There were 8.5 substantively employed staff at the UK Air Alliance location. This included 1 whole time equivalent general manager, 1.8 whole time equivalent medical team, five whole time equivalent pilots, 0.5 whole time equivalent administrative support. The remaining staff were subcontracted with up to 50 staff, made up of a range of nurses, doctors, consultants and paramedics. The staffing ratio minimum was 1:1, often 2:1 (doctor and nurse: one patient) and all were suitably qualified.
- The leadership team deployed sufficient numbers of clinical staff with the right qualifications and skills to keep people safe from avoidable harm and abuse. The registered manager planned staffing levels, skill mix and gender balance to ensure that patients received safe care and treatment at all times. Staff followed various shift patterns, Air Alliance ensured pilots and clinical crew staff always had 12 hour breaks. This was included in their staffing policy.
- Staffing was managed using an online calendar, which was colour coded with each staff member's availability. The staffing mix was a combination of doctors, consultants and nurses. All staff were employed to fly regularly to build their skills base. The senior flight nurse checked if there were any gaps in skills, if so, staff would those staff would not be used. The management team were also qualified nursing and medical staff and if needed could step in. This meant it was rare that flights were not accepted due to competency or staffing deficits.
- Consultants on the staff team could be employed on the flying or medical roster. Staff in Germany and Vienna could also be used on the rota. Staffing numbers varied markedly. The staffing list could be anywhere from 20 to 50 staff. This meant that there were sufficient staffing levels to cover each flight.
- Category of care required determined staffing levels. For example, for those patients who required normal and special care, a specialist registered nurse and senior registered practitioner were deployed. For those patients who were assessed as high dependency, intensive care and high risk intensive care, a cardiothoracic or consultant would form part of the team who transported the patient to their destination. This meant the staffing mix was adjusted to meet the medical needs of each patient.

Records

- We looked at nine paper patient records. They were complete, legible and included all the information needed to assess the level of care and treatment required.
- Staff recorded when they received inadequate medical notes from referring clients. For example, the patient's notes may have not have identified all medical issues which could complicate or preclude safe transfer. The medical coordinator reviewed the notes and looked at existing mitigation. Staff used a client risk matrix to identify organisations who regularly provided inadequate patient information. The leadership team had made the decision to refuse to work with organisations who failed to provide sufficient information.
- Staff completed documentation audits, for example 10 sets of transfer notes were audited for November/ December 2017. Staff carried out documentation audits to ensure records were completed in line with policy. In response to audits, staff had access to a training programmes on how to complete good quality assessments and documentation. The notice board in clinical room displayed an example of good documentation for staff to see.
- All patient information was locked in the clinical room and then scanned into the system to make it electronically accessible. The notes clearly indicated how long they should be retained for and there was a system in place for confidential disposal. The area where records were kept was secure and only medical teams had access to it. Sometimes patient data was sent to the company who paid for the job. This was with patient consent and was password protected before it was securely sent. This meant that there was a secure system with consent required to share and store information.
- Patient information needed to deliver safe care and treatment was often determined by an international

system of computerised exchange. Many hospitals exchanging information were cautious about what they shared. This sometimes meant that not all patient information was received until the point of patient collection.

- Staff were trained in information governance and understood the principles of data protection. Staff told us they treated patient information confidentially which complied with the Data Protection Act. Staff used secure processes to share information and there was a policy and protocols in place to ensure ongoing confidentiality.

Medicines

- Medicines were stored safely and managed appropriately. There was a related policy for prescribed and stored medicines in line with local and national guidelines. Air Alliance had a service level agreement with local hospital NHS trust who provided stock and pharmacy advice when needed. This meant the service was supplied and supported by a local hospital pharmacy department.
- Staff completed documentation to ensure medications were checked and securely stored. The documentation was consistently and accurately completed. The controlled medicine book was signed daily by two clinicians and dated to verify checks were completed. Temperatures for the storage of medicines were recorded appropriately and any medicines relating concerns could be discussed with the NHS trust deputy chief pharmacist for guidance and direction.
- Controlled drug orders were carried out by fax. Ordering sheets were retained for 2 years and supplied by the Home Office. There was a security arrangement for controlled drugs and a policy written and checked by awarding/licensing body. This meant there were processes to ensure standards were met relating to controlled drugs.
- Intravenous fluids were safely and securely stored in a room locked by a key that was kept in a key coded pad. Only clinical staff had access.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Managers worked with referring agents to ensure they had the right information to assess people's physical, mental health and social needs holistically. We were given examples of when clinical staff provided additional support to referring agents to ensure they provided the right information. This helped to make a holistic assessment to ensure care, treatment and support was planned and delivered in line with legislation, standards and evidence-based guidance. For example, National Institute of Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes such as asthma, monitoring airway inflammation, Atrial fibrillation management, diabetes.
- Staff used many NICE guidance documents to ensure they were being evidence based in their approach. For example, we looked at the local protocols that referenced National Institute for Health and Care Excellence guidance links. Staff used care of stroke patients and pressure ulcer prevention documentation. We saw protocols and the use of safety guidelines. All of which supported evidence based practice.
- Staff used an adaptation of intensive care society guidance, which was relevant to their operations. They also used the Royal College of Nursing standards for prescribing and the Royal College of Physicians for National Early Warning Score. This meant they used up to date evidence based guidance to help them make decisions using established standards.
- Air Alliance were an approved provider for European Airomedical Institute (EURAMI) and Commission on Accreditation of Medical Transport Systems. This meant they had met the standards set out by these bodies to ensure their practice was acceptable. Staff were trained, knew and understood the Mental Capacity Act (MCA).
- All staff were expected to keep up to date with developments. For example, the registered manager, a registered nurse, was the chair at the critical care and flight nursing forum. This was a forum for the Royal College of Nursing members working in critical care and flight nursing. The registered manager was also part of the Royal College of Physicians press conference at the launch of NEWS. This meant staff were involved in opportunities to learn and share practice related to their field.

- Staff normalised the journey by wearing every day clothes. There was a protocol for those who presented in a challenging manner. In those circumstances, patients could be chemically restrained. For example, staff were experienced in managing patients with delirium.
- Mortality and Morbidity reviews were discussed at governance meetings. We looked at governance records however there were no recorded mortality cases from UK base. We saw a morbidity review recorded outlining an urgent flight. Leaders discussed the case at length but transfer was declined due to their unstable condition. Alternatives were discussed and conclusions were based on the safety and wellbeing of the patient. We saw other referrals that had been reviewed and declined based on the safety and wellbeing of the referred patient. This meant that all referrals were assessed for suitability and patient safety and prioritised based on whether it was in their best interest to proceed.

Nutrition and hydration

- Staff used Malnutrition Universal Screening Tool and GULP (a dehydration risk screening tool) scores to assess and manage patient's nutrition and hydration needs. Dietary and nutritional needs were assessed in advance and preferences provided where possible. This information was handed over to the receiving hospital staff.
- All aircraft carried a good supply of water and infusions. Staff had limited resources on flights and patients were in their care for a short period of time. The provider had a contract with a local catering company who supplied food for each flight. This could also be tailored to patient's dietary requirements, for example, gluten free or halal. This meant that they met patient patient's nutrition and hydration needs where possible.

Response times/patient outcomes

- The central operations team operated 24 hours a day, 7 days a week and responded to referrals immediately. Suitability and acceptability were considered, as well as the timing and urgency of the transfer. Those who were not medically suitable for transfer were referred back to the referring agent. Patient outcomes were the overall deciding factor for suitability.
- The registered manager told us information about patient care and treatment outcomes were not routinely collected and monitored. However, they told us their audits were benchmarked against EURAMI (European Aeromedical Institute) and Commission on Accreditation of Medical Transport Systems for neonatal and paediatric referrals. They could not fully monitor outcomes. This information would have needed a response from accepting hospitals who could not release the data.
- The service did not submit data to the Intensive Care National Audit and Research Centre (ICNARC) audit, as they are not an admitting unit. However, the leadership team use ICNARC data to help improve outcomes and were regularly invited to conferences. Using this data, they studied the process of level three (high dependency) admission via air ambulance. They collected data on a number of jobs, timing, time taken and any delays getting critically ill patients back to UK. In addition, they looked at waiting times for beds. This meant that they were using data to try to understand and improve outcomes.

Competent staff

- All staff received an induction, which was documented. They were trained in flight specific manual handling, aircraft safety and hanger safety where risks were specific and could be dangerous. The leadership team were in the process of introducing a double module in international aeromedical repatriation and the provider had registered appropriate staff as associate lecturers with Birmingham City University. The induction process meant that everyone had a base level of knowledge that could be built upon.
- Specialist learning was included in the induction, for example, infection prevention and control on an aircraft. There was an anticipated level of cleaning on the air craft which was detailed within induction. All staff were given a copy of a medical operations manual and signed for receipt of it. All staff's first few flights was with a regular flyer. Staff had to be confident that they knew and understood policies and procedures. All staff's competencies, for example, infection prevention and control specific to flights was checked by an

experienced member of staff, however there was limited documentation in staff files to confirm these checks had taken place. The leadership team identified this was an area for improvement.

- Staff could access continuing professional development. This ranged from airway management to human factors awareness. We looked at training certificates in staff files and on a training matrix. We saw up to date certificates relating to, PREVENT, mental health, dementia, as well as others. One member of staff was completing an academic qualification in Bachelor of Science paramedic sciences. This showed that staff were engaged in their professional development.
- All staff were supported to deliver effective care and treatment. Managers told us substantive staff received annual appraisals. However, we did not find a system in place to record supervision sessions, or to monitor appraisals. This meant we were unable to see whether staff were set objectives and were supported in achieving them.
- All registered nurses were required to demonstrate that they were suitably qualified. They did this through revalidation process with the Nursing and Midwifery Council. This was evidenced in all staff files we looked at. The leadership team discussed education and training at monthly governance meetings. We saw that a study day covering essential aviation physiology and safety had carried out on 23 February 2017. This meant that registered clinicians evidenced their continuing professional development.
- The leadership team provided us with an example of how poor, or variable staff performance was identified and managed. They told us staff were supported to improve, however they provided one example of where a staff member had to be dismissed, this meant staff performance was assessed, supported and when necessary staff were dismissed if it meant people were put at risk.

Multidisciplinary working

- All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. There were clinical co-ordinators who were registered senior clinical staff available seven days a week and there was an on-call duty rota. This meant there was a competent person available to co-ordinate care and treatment for patients at all times.
- Leaders could access specialists to join crews when needed. For example, when they needed anaesthetist and intensivist or a senior paediatric clinician.

Health promotion

- The registered manager had a teaching qualification and a post graduate qualification in health promotion. They told us that they promoted wellbeing at all times. They were limited in how much work they do in terms of health promotion, however patient information leaflets formed part of this process.

Consent, Mental Capacity Act

- Staff were trained and understood consent and decision-making principles outlined in the Mental Capacity Act 2005. All patients signed a consent form and a copy was kept in their records. Staff gave us examples of when they identified capacity issues, made best interest decisions involving family and other professionals and made a decision based on the patient's best interests.
- Staff did not use physical restraint; however, they would consider chemical restraint if it was assessed as appropriate.
- Staff assumed capacity unless it was suspected the patient lacked capacity, then made best interest decisions at the time.

Are emergency and urgent care services caring?

Compassionate care

- We did not see any patient interactions or speak with patients; however we did see that staff interacted with each other in a respectful and considerate way. We received compliments directly from people who had used services and we saw feedback from clients who felt the service provided by staff was inclusive, supportive and sensitive to people. One patient said, that staff go the extra mile to ensure patient safety, wellbeing and comfort.

- Staff told us they were mindful of respecting people's privacy and dignity especially in the confined space available on a plane. This included physical or intimate care.

Emotional support

- Staff told us that they worked closely with patients to ensure they were supported in their emotional wellbeing. They gave us examples of when patients might be anxious in a small plane; small aircraft often means more turbulence. Staff were supportive by providing clear information about what to expect from the start, to the end of their journey. Staff sometimes provided anxiolytics in addition to lots of reassurance in advance and throughout.

Understanding and involvement of patients and those close to them

- Staff communicated with people so that they understood their care, treatment and condition and any advice given. Staff were considerate of ways to communicate with people that was sensitive to their individual cultural needs. For example, to provide a male crew member to speak with men who might not find it culturally acceptable to communicate with female crew.
- Staff took patients through what to expect as part of the consent process. This outlined risks inherent, for example, experience of turbulence, dehydration and fatigue.
- Staff assessed the suitability of involving and carrying patient's carers or involving other representatives in the delivery of care. Wherever possible patient's families and other significant people were involved in patient care. If assessed as appropriate relatives and loved ones could travel with the patient, however, each situation was assessed using individual information.

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

Service delivery to meet the needs of local people

- Service was delivered to patients across many countries and staff had access to a number of resources to support them in knowing and understanding the needs of the local population. For example, the Foreign and Commonwealth Office. The information was used to inform how services were planned and delivered.
- Staff were used to working with diverse communities in different countries where there were cultural considerations. For example, many of their patients were transferred from North Africa. This is a country where some women were expected to cover their hair. Staff had access to a headscarf which was kept on the aircraft.
- There were service level agreements in place and staff worked with other providers and relevant stakeholders involved in planning services. For example, working with local NHS trust for medicines and local patient transport services to collect patients from the aircraft to their agreed destination.
- The registered manager told us they protected people from avoidable harm and understood the Equality Act 2010. They did this by employing a diverse mix of staff from the NHS workforce who were used to working the requirements under the Act. Assurance was provided in the form of training and learning from work in their substantive roles and in their contribution to the work with the diverse group of patients they worked with at Air Alliance.

Meeting people's individual needs

- Staff could access aircraft to meet the specific needs of patients and their families. For example, there were planes that could be used for bariatric (heavier) patients and planes suitable for transferring paediatric patients and their families.
- Where safe travelling companions were accepted to accompany a patient, each case was individually assessed and companion support was actively encouraged for patients living with dementia, learning disabilities or at end of life. There were no recent experiences of transports involving patients with learning disabilities or cognitive deficits. For patients at end of life, care would be taken to have family members travel with them. Thought, care and consideration was given to each situation based on their own individual circumstances.

Emergency and urgent care services

- Air Alliance had a clinical partnership with Embrace, a Commission on Accreditation of Medical Transport Systems for neonatal and paediatric referrals hosted by a children's NHS hospital. To meet the needs of neonates there were two incubator stretcher systems. One was an intensive therapy unit and the second was high dependency unit with a portable incubator to help infants receive the critical care they needed by air. These were supported by the latest ventilators and humidifiers, capable of providing comprehensive respiratory support to the smallest of lungs.
- While co-ordinating and planning care, staff considered gender mix and tried to have a mixed gender crew to ensure there were male staff for those patients who culturally find it difficult to communicate directly with female staff. Staff were supported to understand cultural complexities and this was included in security and self-awareness training that all staff received.
- Staff had access to an app on a mobile telephone that would instantly translate both visually and audibly. Staff we spoke with knew how to access and use this facility. This meant they could communicate with patients where English was not their first language.
- Patients had the option of food to suit their individual requirement if possible on each flight, for example, vegetarian options. Staff told us they tried to have a range of food available to patients and those traveling with them.

Access and flow

- A central operations team received each transfer request from referral organisations and a full medical report was requested which should include initial assessment, test results, diagnosis, and treatment. Patient details were discussed with the medical director and senior medical team to confirm suitability and acceptability of the request. The team considered the timing and urgency of the transfer. To ensure safety, there was a care pathway and cross communication between different geographical areas. They used triage levels one to four to establish which staff were required for which level of care. Level four, for example, was high risk intensive care, this meant they would need an intensive therapy unit consultant for the transfer.
- If the patient was assessed as not medically suitable for transfer the concerns were discussed with the referring agent. The medical director had the final say on whether to accept a transfer or not. This meant that suitability and acceptability was assessed by a team of senior clinicians based on whether a patient was safe to transfer.
- The registered manager told us that delays were rare. For example, weather conditions meant flights might be delayed. There could be technical issues when taxiing which might cause delays. There had been incidents where the plane has had to refuel and deal with technical issues prior to take off.

Learning from complaints and concerns

- Staff, people who used services and those who paid for the service could raise complaints and concerns. There was an embedded complaints procedure and related documentation. We saw this evidenced in the service documentation which included how complaints were dealt with and what the learning was. For example, we looked at one complaint where a referring agent had not organised a hospital booking for a patient. This resulted in the provider no longer using the agent.
- All patients were provided with feedback forms and it explained how to make a complaint or raise concerns. There was also the option to complain via the service website. There had been no complaints received from patients. Referring agents were also encouraged to raise complaints and we saw examples of this documented in meetings from minutes. We looked at four complaints from referring agents. Each complaint was reviewed, assessed and shared with staff to drive improvement. They were also dealt with within appropriate timescales.

Are emergency and urgent care services well-led?

Leadership of service

- Staff at senior leadership level were suitably qualified, with substantive clinical roles and specialist training. The general manager had an extensive background in operational aviation and was a trained flight instructor. The medical directors worked substantively in NHS trusts and provided clinical oversight and critical care input.

Emergency and urgent care services

- The leadership team applied strict recruitment criteria. All nursing staff had at least five years post qualifying experience in specialised intensive care. Each staff member whether substantive or sub-contracted had monthly checks with General Medical Council, Nursing and Midwifery Council and the Health and Care Professionals Council. This meant that all staff were checked against these regulatory bodies for issues relating to their registration.
- The leadership team were supported in achieving additional competencies through training and professional development experiences. For example, the registered manager completed a level four safeguarding qualification. The medical director completed a Caldicott Guardian course. This was Staff were involved at a senior level with the Royal College of Nurses critical care flight nursing forum.
- The leadership team had completed accredited management studies courses and other leadership qualifications. Two members of staff had a teaching certificate to assist in training staff. One member of staff had a diploma in end of life care which included ethics, which helped them guide decision making.

Vision and strategy for this service

- The leadership team told us that they did not have a strategy; however, they had a meeting planned on the day of inspection to work on a strategy to reflect the new service.
- As an organisation the strapline was 'We fly for your life'. We saw this on the company literature. The leadership team and staff we spoke with told us their mission statement and values were that they were patient focussed, quality and safety driven.

Culture within the service

- Staff we spoke with told us that they felt supported, respected and valued. This was evidenced in the commitment to ensuring they were supported to develop professionally. Staff told us they were afforded flexibility in their work patterns and that they felt listened to and invested in. Staff told us they worked in a culture where they were encouraged to be open and honest at all levels within the organisation, including with people who used services.
- All staff we spoke with told us that Air Alliance promoted the concept of a 'Just Culture' organisation. This meant there was a culture which encouraged incident reporting without blame. We saw a poster in the staff area about 'Just Culture'. The poster explained to staff how to raise complaints and incidents.
- Staff were encouraged to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes. However, staff could not provide us with examples of when this might have happened.

Governance

- The leadership team did not always assure themselves that sub-contracted patient transport services on the ground had all the relevant checks. For example, one sub-contracted service did not have up to date insurance certificates and all the relevant checks in place to ensure they offered a safe service when transporting patients.
- There were good systems to ensure staff received all the necessary checks to keep people safe. For examples, certificates of competence and recruitment processes.
- There were governance arrangements in place for safe medicines management. There were systems policies, processes and practice with a service level agreement with a local NHS trust for supply and audit.

Management of risk, Issues and performance

- There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes
- There was a programme of internal audit to monitor quality and operational processes, and systems to identify where action should be taken. We saw this managed at varying levels and evidenced in audit feedback documentation, governance meetings which included managing risk.
- The leadership team compiled a risk register with the input of all employees. The risk register was site specific and included incidents, findings and processes. There were three areas of focus; medical, flight and general risks. All risks had a summary of consequences and mitigation. Any new risks were added to this register and the document was discussed at monthly governance meetings.

Information management

- The medical director was the Caldicott Guardian who had completed an associated masterclass in April 2018 and registered with NHS Digital in June 2018. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly". the Caldicott Guardian was to act as the "Moral Compass" of the company. They ensured that choices made were clinically correct, ethically appropriate and not primarily driven by commercial concerns. We saw this evidenced in the decisions made when assessing and accepting suitability of patients.
- Trained staff used an integrated web-based quality and risk management system for aviation. The electronic system supported staff in accessing and completing real time entries on to patient reports and risk assessments. This meant that trained staff, of which there was one on a flight could access real time information to help them make decisions and use the information to effectively to monitor and improve the quality of care.

Public and staff engagement

- People's views and experiences were gathered using feedback forms. The registered manager told us that feedback from people who used the service was predominately positive. Staff were engaged to ensure their views were reflected in the planning and delivery of services and in shaping the culture.
- 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. Staff engaged with services across countries and considered their views and to deliver services to meet those needs.

Innovation, improvement and sustainability

- The leadership team told us they were regular contributors to industry publications (International Travel Assistance Journal) and that they were Invited speakers to national (Royal Aeronautical Society) and International Tourism and Investment Conference. They also contributed to the audit of UK intensive care unit admissions.
- Staff were involved in a piece of work to identify frequency of repatriations from overseas, raise national awareness and formalise guidelines. This meant they were working to ensure they were an improving organisation.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Sub-contracted patient transport services on the ground should have all the relevant checks in place to provide assurance that they had up to date insurance certificates and all the relevant checks in place to ensure they offer a safe service when transporting patients.
- Patient outcomes should be monitored and used to make improvements.
- There should be a business strategy that outlines the objectives and plans for the service.
- Staff competency observations should be documented to evidence staff were safe to carry out their duties.
- Managers should have a system in place to hold, document and review annual appraisals and supervision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...