

Capital Air Ambulance Ltd

# Hangar 68, Exeter International Airport

## Quality Report

Hangar 68  
Exeter International Airport  
Exeter  
Devon  
EX5 2BD  
Tel: 01392 350020

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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

Emergency and urgent care services

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Capital Air Ambulance is an aeromedical transport service providing emergency and urgent care, run by Capital Air Ambulance Limited.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 12 December 2017, along with a further visit on 18 December 2017.

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:

- Incidents were investigated and actions were taken where appropriate.
- Medical equipment and aircrafts were regularly serviced, maintained and safe for use.
- Thorough risk assessments were carried out prior to missions taking place.
- Infection risks associated with patients were actively assessed to prevent and control the spread of infection.
- Patients' individual care records were written and managed in a way which kept them safe. They were up to date, identified individual patients' needs, detailed the individuals' care needs and the treatment provided during the mission.
- Staffing levels and skill mix were planned according to the needs of the individual. This ensured patients received safe care and treatment.
- Care and treatment was based on nationally recognised guidance which had been tailored to meet the requirements of the aeromedical environment.
- Patients' individual needs were assessed and planned to ensure they received the correct care and treatment to maintain their safety and wellbeing during the mission.
- The service monitored the quality of its response times for commissioned contracted work, against specified key performance indicators.
- Staff had the skills, knowledge and experience to deliver effective care and treatment and underwent bespoke professional development in aeromedical care and treatment.
- The service coordinated care and treatment with other providers to ensure the effectiveness of the mission.
- Information needed to deliver effective care was accessible to relevant staff in a timely way.
- Staff gained consent before providing care and treatment. They also knew how to make decisions in patients' best interests when required.
- Feedback from people who used the service was consistently positive. Comments written by service users praised the medical and aviation staff for the way they treated people with dignity and respect.
- The service understood the importance of communicating with a patient's next of kin and keeping them informed.
- Staff provided emotional support for patients during a time of high anxiety and uncertainty.
- The service worked closely with the commissioners for the contracted work to ensure services were planned and delivered to meet the needs of the patients.
- The office was staffed and operational 24 hours a day, seven days a week to fulfil the terms and conditions of the commissioned work.

# Summary of findings

- Some of the clinical staff were able to support the care and treatment of patients whose first language was not English.
- The governance framework supported the delivery of good quality care, although some processes needed to be formalised and carried out more regularly to identify areas where quality could be improved.
- The service maintained risk registers which were reviewed regularly to effectively monitor and manage risks to the service.
- Leaders were supportive and approachable, and staff felt valued.
- The service engaged with patients and stakeholders to receive feedback and identify areas for improvement.

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

- A small number of policies we reviewed not always based on the most current legislation and guidance.
- There was no formal system or process to track which members of staff had received an appraisal and not all staff who had carried out a specified number of missions had received a recent appraisal.
- There was no formal process to ensure the quality of the service provided by the preferred ground ambulance providers used to support missions.
- There was no formal programme of clinical or internal audit used to provide a clear oversight of the service to monitor quality to identify areas for improvement.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices. Details are at the end of the report.

Amanda Stanford

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

# Summary of findings

## Our judgements about each of the main services

### Service

#### Emergency and urgent care services

### Rating Why have we given this rating?

Capital Air Ambulance Limited is an independent air ambulance service in Exeter, Devon providing 24 hour service, seven days a week, 365 days a year.

The service has recently renewed its contract with a healthcare provider outside the regulatory authority of the CQC to provide aeromedical transport to patients. Medical and commercial repatriation is also provided.

We do not currently have a legal duty to rate independent ambulance services but we highlight good practice and issues that service providers need to improve.

We found areas where the service performed well during our inspection. For example, medical equipment was well maintained and safe for use, thorough risk assessments were carried out and individual patient needs were carefully assessed and planned to ensure patients received the most effective care and treatment during the mission. The service understood the importance of keeping patients and their next of kin informed and supporting patients emotionally. All feedback we received about the service was consistently positive.

However, there was no formal programme of clinical or internal audit used to monitor quality or to identify areas for improvement, or formal process to ensure the quality of the service provided by the preferred ground ambulance providers used to support missions.

There were several other areas where improvement was required, however the service started to rectify the issues raised both on the day of and following the inspection. We were provided with an action plan following the inspection which included evidence of actions which had been taken and implemented to improve the service.

# Hangar 68, Exeter International Airport

## Detailed findings

### Services we looked at

Emergency and urgent care;

# Detailed findings

## Contents

### Detailed findings from this inspection

	Page
Background to Hangar 68, Exeter International Airport	6
Our inspection team	6
Facts and data about Hangar 68, Exeter International Airport	7
Our ratings for this service	7
Findings by main service	8
Action we have told the provider to take	26

## Background to Hangar 68, Exeter International Airport

Capital Air Ambulance opened in 1991. It is an independent air ambulance service in Exeter, Devon providing 24 hour service, seven days a week, 365 days a year. The service has a fleet of 11 aircraft.

The service carried out executive passenger flights from 1991 until 2011 when the scope of the business developed to include air ambulance work. At this time, a medical director with expertise in the aeromedical field was appointed to oversee the development of the service. The service has recently renewed its contract with a Healthcare provider, outside the regulatory authority of the CQC, to provide aeromedical transport to patients. Medical and commercial repatriation is also provided.

Capital Air Ambulance offers all levels of medical care for adults and children, including premature and neonatal babies, and has level three intensive care capability. The service specialises in providing aeromedical transport of the most ill and severely injured of patients, for example patients who are normally managed in an intensive care unit (ICU) or specialist high dependency unit (HDU), such as for coronary care. The service also provides transport to patients with other medical conditions requiring treatment by doctors and nurses.

The service has had a registered manager in post since 1991.

The provider is registered to provide the following regulated activities:

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

Capital Air Ambulance Limited was last inspected in January 2013. During this inspection, the service met all the standard requirements it was inspected against. There have been no previous requirement notices or enforcement actions associated with the service. We carried out an announced inspection of Capital Air Ambulance on 12 December 2017 and revisited the service on 18 December 2017.

The CQC only regulates services provided in England. Medical repatriation services are also within our scope of regulation if the patient pays privately for the service.

## Our inspection team

The team that inspected the service comprised of a CQC lead inspector, and one other CQC inspector. The team

# Detailed findings

also included two CQC inspectors from the medicines optimisations team and one assistant inspector. The inspection team was overseen by Daniel Thorogood, Inspection Manager and Mary Cridge, Head of Hospitals Inspector.

## Facts and data about Hangar 68, Exeter International Airport

During the inspection we visited Capital Air Ambulance's base at Exeter International Airport. We spoke with 32 members of staff, including the directors, chief flight nurse, the medical director, flight operations controllers, flight nurse co-ordinators, the compliance manager, nurses and doctors. We were unable to speak with any patients because there were no missions scheduled to arrive at the airport during our inspection. We received five 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed the records from 10 missions.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity (January 2017 and November 2017)

- Between January 2017 and November 2017 the service had carried out 1350, emergency and urgent care missions.

At the time of our inspection, there were 132 members of staff on bank contracts working for the service, 16 contracted members of staff and 16 full time pilots. Only a small number of bank staff regularly carried out missions for the service.

Track record on safety:

- No serious incidents
- Five complaints

## Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

# Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Summary of findings



# Emergency and urgent care services

## Are emergency and urgent care services safe?

### Incidents

- There was a system and policy to report and respond to incidents. The incident reporting system was paper based. Staff completed an incident report which was reviewed by the chief flight nurse who took appropriate action to investigate the incident and record any learning or actions taken from the investigation. 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 when the investigation was complete.
- There had been nine incidents reported since January 2017. We reviewed the five most recent reported incidents. These included equipment malfunctions, provision of the incorrect patient notes by the referring hospital and issues encountered with ongoing transport to the final hospital destination. Staff were included in investigations when required. Learning was shared using the electronic Centrik system however the senior management team felt they could ensure learning was shared more effectively with the clinical staff. Following the inspection, the service provided us with an action plan. The flight nurse co-ordinator has been tasked with the role of providing feedback and learning from incidents by email more widely to the clinical team when required.
- An electronic overview of all incidents reported was maintained by the service. The electronic record included a description of the incident, the outcome and any recommendations following the investigation outcome.
- The service reported incidents involving aircraft safety separately, in line with Civil Aviation Authority regulations. Reports were added to an electronic system where they would be reviewed by the safety manager, risk classified and then an investigation would be carried out by the air worthiness manager. There had been 43 incidents reported and investigated since January 2017. Incidents reported included actions which needed to be taken to prevent incidents from

occurring again. A monthly report was produced and discussed during senior management team meetings to ensure incidents had been appropriately investigated and managed.

- Duty of candour was part of the business information document, identifying the structure, ethos and function of the service. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. The document explained the duty of candour and the principals of being open and transparent with service users when things go wrong. The document also included information about specific requirements which would be carried out if the duty of candour had to be initiated. At the time of our inspection, there had been no requirement for the application of the duty of candour.

### Mandatory training

- Staff received mandatory training in safe systems, practices and processes. Members of the clinical team completed mandatory training at their current place of employment in the NHS. The service required evidence from the staff member's current NHS role of their compliance with mandatory training; however, at times they struggled to obtain this information. The service did not allow staff to take part in missions until they provided evidence of compliance with mandatory training in their current organisation. The service was aware of the issues with this process. They had been working on developing a new system, without the challenge of obtaining the required documented evidence.
- The service was due to launch a new system to ensure better oversight of mandatory training compliance for the workforce. The service had set up their own internal mandatory training programme to overcome the challenges in obtaining the information from the NHS trusts. A senior member of staff told us the mandatory training programme had been set up in conjunction with an external provider. Once implemented, all staff would complete this training on a yearly basis. This

# Emergency and urgent care services

programme was due to be implemented in January 2018. Topics were to include consent, safeguarding adults and children, infection control, fire safety and moving and handling.

## Safeguarding

- There were systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse. The service had policies available, however two of these referenced out of date guidance and legislation. There was a safeguarding service users from abuse policy, protecting vulnerable adults and a child protection policy available for staff. These were easily accessible on the electronic system even when airborne, and included the details for the relevant local authority where concerns must be reported to. The policies outlined what safeguarding was, its importance, and provided definitions of the different types of abuse. The policies also covered staff responsibilities with regards to raising safeguarding concerns and the procedure by which to report these. The safeguarding service users policy had been reviewed in March 2017, however still made reference to the Health and Social Care Act 2010 rather than the Act which was updated in 2014. The child protection policy also made reference to the working together to safeguard children document 2010 revised 2012, rather than the 2017 document.
- Senior staff told us as all staff had current, permanent roles in NHS organisations and received safeguarding training as part of these roles. The service had been open about their struggle to obtain the relevant assurance around mandatory training. Plans were in place to provide safeguarding training as part of a new mandatory training package. Senior staff told us staff who worked with children were trained to safeguarding children level three, and level two for adults.

## Cleanliness, infection control and hygiene

- There were systems and processes in place to protect people from the spread of infection. The provider was able to demonstrate how they were assessing the risk of infection and taking action to prevent, detect and control the spread of infections. The provider had a policy in place for infection prevention and control dated 2015. This included advice and guidance for staff to follow about cross infection, and how to minimise any risks.

- All of the staff held current positions in the NHS and undertook infection control training as part of their roles. Senior staff told us they were having difficulty in obtaining evidence of this and were looking to provide this training as part of a package of mandatory training that was due to be introduced shortly.
- There was evidence to suggest patient-related infection prevention and control risks were considered and managed appropriately prior to the mission. Information was collected to make sure staff were prepared and the aircraft was cleaned in accordance with policy once the mission was over. If the patient was known to have an infection, a deep clean would take place prior to the aircraft being used again. Senior staff told us part of the kits taken on board the aircraft included personal protective equipment, including gloves, aprons and hand gel. If a patient needed to use a bed pan or urine bottle during the flight, a specialist powder was used to turn any liquid into gel. This was then double bagged in clinical waste bags ready to be disposed of following the mission. Specialist cleaning wipes were also taken on board the aircraft for cleaning and to prevent the spread of infection when airborne.
- There was a procedure for the disposal of linen used, which included soiled linen with bodily fluids. The provider had a contract in place with a specialist company. We saw supplies of red bags which were used for linen that had been soiled with bodily fluids. These were then put in another bag and put into a container back at the aircraft hangar whilst waiting for collection. Clean linen was also replenished.
- Records used to demonstrate cleaning of the aircraft had recently been amended as the previous records were not being completed. We were shown copies of the amended form which showed they had been completed. A senior member of staff told us deep cleans of the aircraft took place after 30 days or if an infectious patient had been transferred by an external company. Senior staff monitored this but we were not shown any records to demonstrate how this was done on the day of the inspection. Following our inspection, we were sent evidence of records maintained to demonstrate aircraft deep cleaning had taken place. Only one aircraft was present during our inspection and we found this was visibly clean. All medical equipment was cleaned by the staff and was then ready to be used again.

# Emergency and urgent care services

- A fluid spill kit (a kit to clean up spillages of bodily fluids) was included in the kit bags taken on the aircraft for each mission and these were replaced when used.
- We were not able to observe any patient care during our inspection so we were not able to observe staff washing their hands or other infection control practices. However, staff told us they had access to hand gel and gloves when on the aircraft.
- The service had an infection control lead for the organisation who staff were able to go to for advice and support.

## Environment and equipment

- The maintenance and use of equipment kept patients safe during their journeys. Aircraft were checked prior to being flown by suitably trained technicians. Aircraft had to meet the requirements of the Civil Aviation Authority (CAA). A maintenance contract was in place for the maintenance and servicing. One of the aircraft was being serviced and maintained during our inspection.
- Medical equipment was stored ready for use. Clinical support staff checked the medical equipment on a daily basis. This ensured equipment was working and whether additional equipment needed was present, for example paper for the monitors. Equipment for adults and children or babies was available and stored in separate rooms, all ready for use.
- The provider had a selection of medical equipment based on the needs of the patients using the service. For example, if a patient needed full ventilation (help to breathe using a machine) and monitoring of their vital signs, equipment was available to carry this out. For ease, the provider had separated the medical equipment depending on the condition of patients using the service. For example, if a patient was assessed as needing intensive care during the mission the staff would take one of the three kits prepared for this. These contained, for example, a ventilator, monitoring machines, syringe drivers and several 'kit bags'. The kit bags contained other equipment which might be needed, such as syringes, suction equipment, spare batteries and needles. A bridge (a stand) was provided to safely sit the equipment on, above the stretcher, when airborne.
- A bedding bag was also taken on each mission. This included sheets, pillow cases and a lifting sheet. A mission checklist was available to make sure staff had all the required equipment for a mission. This checklist was completed and signed off by the clinical staff allocated for the mission.
- Kit bags were reviewed on a monthly basis. Senior staff told us each month all kit bags were opened, checked and re-sealed if they had not been used to make sure all equipment was in place and consumables were in date. Staff had to sign when they checked these bags and re-packed them. This was used as evidence they had been done and to demonstrate the accountability of the staff completing these tasks.
- The arrangements for managing waste and clinical waste kept patients safe. For each mission staff took a selection of waste bags, including clinical waste bags, to dispose of any waste during the flight. Once on the ground these were disposed of at their base in a clinical waste bin. A specialist contract was in place for the emptying of this bin. However, when we viewed this clinical waste bin the lid was open and the contents were on display. This was because the lock was damaged. We reported this to senior staff who said they would address this immediately. Following our inspection the provider sent us an action plan which confirmed the lock had been fixed. The clinical waste bin was stored near to the hanger where the aircrafts were stationed. This is a non-public secure area which meant unauthorised people did not have access to it.
- The service had suitable arrangements in place to receive notifications and alerts for medical equipment and consumables.
- There were suitable arrangements to ensure medical devices were being serviced and maintained appropriately.
- Stretchers used to transport patients had pressure relieving qualities within the mattress to reduce the risks of pressure ulcers. For patients who were at risk, an extra mattress was available to sit on the top of the stretcher. For patients who had unstable spinal fractures, a specialist mattress was provided to reduce the risk of movement when airborne.
- 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

# Emergency and urgent care services

fault so it could be returned to use. Staff told us this took place quickly and if the equipment was not able to be repaired the provider would replace it with a new piece of equipment.

## Medicines

- Medicines were not always stored in line with manufacturer's recommendations and oxygen was not stored securely in a locked area.
- There was a medicines policy available, although it required updating to reflect current practices in medicine such as ordering, storage, and disposal. However, following the inspection, the service provided us with evidence to demonstrate the medicines policies had been reviewed and updated to include references and information from the most recent legislation and guidance available.
- Medicines which patients may have required during the flight were checked in advance. Arrangements were in place to work with other healthcare professionals to deliver established care routines. If a medicine originally prescribed was not available during the flight, suitable arrangements were made to provide an alternative. Medicines administration was documented in the patient's record.
- Temperatures for the refrigerators and one of the medicines storage rooms were recorded daily, and were within the recommended range. However, the room temperature for the second medical store room was not being recorded. This meant there was a risk that medicines were being stored outside of the manufacturers' recommended temperature. The day of the inspection was very cold. The provider also identified that they would install heating into the store room to maintain a minimum temperature. However, since the inspection, the service provided us with assurance that a temperature sensor had been fitted and room temperatures were being monitored. During individual missions, the service had suitable arrangements to maintain the cold chain.
- 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 drugs licence was on display. Controlled drugs were stored securely and access was restricted to appropriate individuals. The controlled drugs register showed the transfer of

controlled drugs with the aircraft and regular stock checks were completed. During the mission, controlled drugs were stored in a locked box and fastened to the plane with access limited to clinical staff only.

- Medicines were stored securely with access restricted to authorised individuals. There was 24-hour surveillance via CCTV.
- The service did not have suitable arrangements in place to action medicines safety alerts and recalls. Following the inspection, the service provided us with assurance they had registered for alerts from the Central Alerting System and would be managing them as required.
- The service kept a stock of medical gas cylinders. At the time of inspection, the latch on the oxygen shed door was broken, which meant the cylinders were not stored securely in a locked area. Following the inspection, the service provided an action plan identifying the latch had been repaired.

## Records

- Patients' individual care records were written and managed in a way which kept them safe. We found patients' records were accurate, complete, legible, up to date and stored securely. We observed patient records were stored in locked cabinets in the main office with only designated staff having access to them.
- The clinical team used paper records to collect the medical information about the patient, to enable them to ensure the correct clinical team and equipment was available for the mission. The form included prompts for necessary medical information required, such as a working diagnosis, initial problem list, information about the presenting complaint, past medical history, current physiological status, outcomes of medical investigations and current medicines. The form then required the clinician managing the mission to identify the relevant problems and any considerations for the transfer. Senior managers knew about all missions being planned and carried out by the service and provided input and support. During the inspection, we saw members of the team frequently discussing missions and their plans with the senior team and the senior team enquiring about current missions.
- We reviewed 10 patient records. Senior staff told us they were given copies of patient medical records, which included X-rays, scans and other important medical information by the clinical location they were transferring the patient from, for the mission. These

# Emergency and urgent care services

records were then passed onto the receiving hospital on arrival. A pre-flight assessment record was completed by a senior member of staff, for the staff who would be undertaking the mission. This contained details about the patient, for example their name and address, past medical history, any medicines they were taking and the reason for their transfer. Special considerations needed for the mission were also included, for example if a patient had communication difficulties. Records were maintained during the mission of the patient's condition, observations, any medicine administered or treatment provided. Staff on the mission also completed the mission checklist and this was signed by all staff present.

- We saw documented in one patient's records that they had a do not attempt resuscitation form (DNACPR). This was documented on the pre-flight assessment form so staff undertaking the mission were aware of this.
- Senior staff showed us a copy of their record of the patients' mission, and confirmed this was also given to the location the patient was being transferred to, along with their medical records.
- The service created an electronic flight plan using a bespoke designed electronic system introduced to the service one year ago. The system consisted of several stages and enabled the flight operation controllers to seamlessly make flight plan arrangements for requested missions. Once complete, the plan was saved electronically and a printed copy maintained in the patient's trip file. Information was then sent to the necessary people at various destinations to make final arrangements for the aviation side of the mission.
- Trip packs were prepared for each patient and accompanied the patient from their initial location to their arrival destination. Documents in the trip packs included administration forms, the initial referral, patient information, the flight plan and the route to be taken.

## Assessing and responding to patient risk

- Comprehensive assessments of risk were completed to safely manage and mitigate risks for patients during each mission to maintain their safety. For patients who were assessed as having complex risks, we saw detailed plans as to how the team planned to minimise and mitigate the risks to enable the patient to be transferred to another location via an aircraft.

- Contracted work for the healthcare provider outside the regulator authority of the CQC classified a patient's condition according to their level of risk when referring into the service. The contract outlined four levels of risk, with each requiring a different response time from the service. Patients referred as critical required a response within four hours, and urgent patients required an eight hour response. Standard patients required a 24 hour response, while elective patients had a future date specified in advance. The service was compliant with a response if they were on the island and with the patient within the specified timeframe. This was monitored and reviewed by the service for each mission.
- A risk assessment would be carried out for bariatric patients referred to the service. If a bariatric patient was referred to the service under the contracted work, the referring hospital would also complete additional paperwork to identify this. A risk assessment was then carried out by the service to ensure the aircraft equipment, the steps and door width did not pose any limitations or risk to the patient, staff or aircraft. Aircraft limitations were included on the documentation to support with the risk assessment. Prior to the mission, the pilot also completed a risk assessment to ensure both aircraft and clinical crew safety. If the risk could be managed safely, the service was able to accept the patient. We were unable to review a completed risk assessment during the inspection because there had been no recent bariatric missions and previous records had been archived.
- The service used bespoke algorithms to identify risks to patients with varying conditions during the aeromedical transfer. These were developed and written by the medical director due to his vast experience in the field and lack of national guidance available for aeromedical transport of patients. Each algorithm had an accompanying policy and procedure to manage the risks for aeromedical transport of specific medical conditions. This included post spinal injury, cardiac condition and sub arachnoid haemorrhage (bleeding in the brain). Where possible, risk assessments based on physiological and other factors supported the clinical team to make decisions about the type of aeromedical crew required for the flight. Where appropriate, the risk assessment also identified the need for consideration as to whether it was appropriate to carry out the mission due to compromising patient safety during the flight.



# Emergency and urgent care services

- Senior staff told us about a patient who they had recently transferred from abroad back to the UK following an accident. We saw this patient had a number of risks which had been assessed and a very detailed management plan had been identified with actions on how to eliminate or minimise the risks. Staff told us the mission went ahead successfully.
- Risk assessments for venous thromboembolism (VTE) were undertaken for each patient in line with national guidance. Senior staff told us the doctors were able to prescribe treatment if needed. We saw recorded on the risk assessment any actions taken or if patients had received treatment prior to their transfer.
- All patients were monitored during their missions to help detect any deterioration in their condition. Senior staff told us of the importance of completing a thorough assessment of the patient prior to the mission to make sure they had all the required medical equipment on board the aircraft. We saw records demonstrating patients vital signs (blood pressure, pulse and breathing) were monitored throughout the mission.
- Staff had access to medical support during their missions. Support was available from either the doctor present on the mission or the medical director who was available 24 hours a day, seven days a week. The medical director was aware of all missions taking place and those that may need his assistance. The medical director had access to the necessary information prior to receiving a call from staff.
- Senior staff told us any patient assessed as being agitated or who demonstrated aggressive behaviour would need to have a detailed risk assessment completed due to the dangers with flying. They told us they did not use physical restraint and if a patient was transferred in this condition, sedation was used to ensure the safety of the individual and staff.

## Staffing

- A recruitment procedure was in place to safeguard patients against unsuitable staff; however, not all files contained references for staff members. We reviewed the recruitment files for eight members of staff employed by the service. The files contained most of the required information to meet the legal requirements, including Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff files included evidence of identity checks or a recent photograph. However, there was limited evidence of the

individual staff members' conduct in their current employment. Of the eight files we reviewed, only four of the files contained a reference for the individual staff member. Following the inspection, the service sent us a new recruitment checklist which had been developed, and was to be implemented moving forwards. The checklist was developed to support with the recruitment process to ensure the correct documentation was received in line with Schedule 3.

- The service was not compliant with the Revised Code of Practice for Disclosure and Barring Service Registered Persons 2015. Copies of staff DBS certificates were held in seven out of the eight staff files we reviewed. The code of practice states retention of the DBS check should be no longer than six months. To comply with data protection legislation about the retention of confidential personal information, DBS must not be stored by the provider and must be given back to the staff member. Following the inspection, the service provided us with an updated action plan identifying DBS checks had been removed from individual staff files following the inspection. The service now maintained just the DBS certificate number and the date of issue for each staff member. This formed part of the new recruitment checklist providing a prompt for staff and space for the information to be completed. The newly developed recruitment checklist also contained a prompt that DBS checks should be returned to the applicant and that a copy was not required for the staff file.
- There was a process to check healthcare professionals held current registration with a professional body. The human resources department maintained an electronic record of each individual member of staff and reviewed professional registration on a yearly basis.
- The service had a bank of doctors and nurses who worked for the service on a bank contract. There were 52 doctors, 75 nurses and five paramedics on the bank for the service. The clinical staff were specialists in areas such as intensive care, neonatal, paediatrics, accident and emergency, acute specialities and specialist critical care. These staff all held current active roles in their various specialities, around the country in the NHS. The service also employed 16 full time contracted staff, such as flight nurse co-ordinators, engineering and safety managers, and 16 full time pilots.
- Staff signed to opt-out of the European Working Time Directive. The Working Time Regulations provide staff

# Emergency and urgent care services

rights to a limit of an average 48 hours a week on the hours a worker can be required to work. Although, individuals may choose to work longer by "opting out" of paid annual leave of 5.6 weeks a year.

- Some staff who held full time contracts with the service worked staggered shifts to enable a 24 hour, seven day a week service to be provided. Flight operations controllers worked a four days on and four days off shift pattern. Staff would work a 12 hour shift and cover either the day shift or the night shift. The shift system ensured there was a member of staff to respond to and action any critical or urgent flights requested via the service's contracted work. The staggered shift system also enabled the service to meet the key performance indicators set out for the commissioned work with the healthcare provider referring the commissioned work.
- The clinical team provided cover during working hours five days a week, and provided rotational on call cover overnight and at weekends. This enabled a 24 hour, seven days a week service to be provided. Rotas for the flight nurse co-ordinators were planned by the team in advance, along with the on call rota. Each flight nurse co-ordinator provided on call cover on one weekend per month. Staff had access at home to the service's systems and the required information when on call.
- Doctors and nurses working under bank contracts informed the service of their availability via an online calendar. The service was informed one month in advance of individual staff members' availability for duty. We were told it could be challenging at times of high demand, different times of the year and even the time of day to align availability of staff to the requirements of the patients and the mission. The provider had a system to alert employees when additional staffing was required at short notice. This system was useful when the team were unable to source the right clinical team for the mission, or during times of increased demand. A text message was circulated to all of the doctors, nurses and paramedics on bank contracts for the service. We were told this system was reasonably successful and employees responded well to request for additional resource.
- Staffing levels and skill mix were planned to ensure patients received safe care and treatment by the best-qualified professional to meet their individual needs. The service used bespoke designed algorithms to determine the staff required for the mission. The document consisted of a flow chart to determine the

most appropriate team based on the information provided at the point of referral. The medical director or the chief flight nurse authorised the final logistical medical plan for each individual mission.

- We observed a daily meeting where senior staff met to discuss the transfers happening that day, as well as those within planning stages. Any issues which had arisen the previous day were also discussed. Staffing availability was discussed, and for any new missions decisions were taken as to the most appropriate members of staff suited for the mission. The discussion also included updates for transfers placed on hold due to the condition of the patient.
- All staff who worked with children held specific qualifications in paediatric care, or had extensive experience of working with children.

## Anticipated resource and capacity risks

- 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 every mission to ensure it was safe to fly and the final decision was made by the pilot. The pilot would monitor the weather by using the electronic system or an application they had available to them on their mobile phones. Once it was safe to fly, a new flight plan was issued to all parties and the mission would be commenced.
- To accommodate short notice work or unanticipated events such as sickness, the service aimed to ensure two doctors and nurses were available, within two hours of the airport and able to be away from home for the duration of the transfer. The rota identified this cohort of staff who were contacted should a short notice request be made. .
- The service was experienced in managing risks, including the inability to source a hospital bed for patients requiring repatriation to the UK. At times the service would be requested to locate a hospital bed in the UK for patients by travel or insurance companies. The service would work closely with the hospital to secure a bed for the patient, however at times this could be challenging. The service would provide regular updates to the patient, their family and the

# Emergency and urgent care services

commissioning company. The service would also communicate regularly with the hospital the patient was at to monitor the patient in case of deterioration in the patient's condition that might require plans to change.

## Response to major incidents

- Capital Air Ambulance Limited did not have their own bespoke business continuity policy. The policy used was that of the company which owned 80% of the business. The policy stated 'every year, as part of the formal monitoring and reporting requirement, the business continuity management process must be reviewed and signed-off to demonstrate that its performance and effectiveness meets the expectations of the various review bodies.' We raised this issue with the service during the inspection. Following the inspection, the service sent us a copy of their newly drafted business continuity policy which was awaiting ratification at the next senior management meeting in January 2018. The new policy identified a six monthly drill was to be completed to enable staff to walk through the process. This would ensure their familiarity with the process in case it needed to be implemented in a real emergency.
- The service held a response plan in case of an emergency situation such as an aircraft accident. The policy outlined the role and responsibility of staff during this scenario and had checklists to ensure all the required information was collected. The policy was available to all staff and also to the pilot and clinical crew in the air on a mission via the electronic communication system.

## Are emergency and urgent care services effective?

### Evidence-based care and treatment

- The care and treatment of patients was based on nationally recognised guidance. However, this had to be 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. The medical director had written and contributed to the small amount of literature available to provide support

and guidance in the aeromedical industry. Some systems and processes within the service were bespoke to meet the needs of the service and the patients using it.

- Nationally recognised guidance was used to determine the level of critical care required for adult patients. The Intensive Care Society publication 'Levels of Critical Care for Adult Patients - Standards and Guidelines' (2009) set out the level of patient need in a hospital environment. The service was using a tool based on these guidelines which had been specifically developed for the aeromedical industry by the Clinical Considerations in Aeromedical Transport. This meant individual patients' needs could be identified and the most appropriate staff identified for each mission, to effectively manage care and treatment requirements.
- The service was accredited by the European Aero-Medical Institute (EURAMI). EURAMI provides voluntary accreditation to air ambulance providers. The association aimed to promote air rescue, to develop and harmonise quality standards and to improve patient care and safety in air medical transport. To become accredited, the service had to meet specific standards in seven areas, for example business ethos and processes, safety and quality management, medical management and clinical practice.
- A small number of policies were not always based on the most up to date legislation and guidance. We found policies referencing the previous Health and Social Care Act 2010. We were unable to review all policies during the inspection due to time constraints therefore we are unable to identify whether there were similar issues with other policies. We raised this issue during the inspection to the medical director who told us the policies would be reviewed following the inspection to ensure they referenced the most current legislation and guidance. The action plan provided following the inspection had allocated named individuals to carry out policy reviews, although no timeframe for completion of this work had been identified.

### 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 additional medical advice and support via the medical director for the organisation. Due to the condition of some of the patients, doctors were present



# Emergency and urgent care services

during the mission. Due to the condition of some of the patients, anaesthetic, intensive care or emergency medicine doctors often formed part of the flight medical team. Neonatal and paediatric specialists were also used accordingly.

- Patients' nutrition and hydration needs were assessed and met during the mission. If the patient was able to eat and drink, in-flight refreshments were provided by the organisation and records were maintained of their input. For patients who were nil by mouth, hydration could be administered intravenously by the clinical staff. This was also recorded.
- During a transfer, patient monitoring included pain. Pain relieving medicine was prescribed in anticipation or, if the doctor or other health care professional covered under the service's guidance on prescribing and dispensing was accompanying the patient, at the time the medicine was required. Clinical staff were able to access and administer pain relieving medicines throughout the mission. At times, pain relief had been prescribed prior to the mission.

## Response times and patient outcomes

- The service monitored compliance against the four key performance indicators (KPI's) of mission urgency as set out in the contract by the commissioners for the contracted work. There was only a contractual requirement to monitor the response times and compliance against the KPIs for the contracted work. The service maintained a spreadsheet identifying the details of the mission, the requested response time and whether compliance against the KPI had been achieved. If the service had not been compliant with a KPI, the reason for this was identified on the spreadsheet. This information was then reviewed by the senior management team as it occurred, but also at the quarterly contract meetings held with the commissioners.
- There was no contractual agreement for the service to maintain details of response times for the healthcare provider referring part of the commissioned work to the service. This was due to the nature of the contract agreement and the service only providing the aircraft for the mission. Despite this, the service maintained a spreadsheet with details of the mission and any delayed

take offs, outside of the flight plan. Reasons for the delay were identified and reviewed and investigated as they occurred to reduce the likelihood of this occurring in the future.

- Patient outcomes could not be monitored due to the nature of the service provided. The medical director told us safe delivery of the patient to their destination hospital was deemed a positive patient outcome. We were told the service had no ownership of the patient and no rights to know anything about the patient other than what was required to ensure a safe transfer mission. If a case was particularly complex or interesting the service would try to follow up the patient where possible.

## Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. There were eight opportunities annually for staff to attend continuing professional development (CPD) days within aviation medicine. We saw the CPD plan for 2018 which included both in house and external training. In house training included classroom discussion sessions, case discussions, competence revisions and simulated practice sessions.
- There was a process to review staff competencies throughout the year. This was completed during the CPD training they received. These training days were also used to make sure staff had the skills needed to meet the requirements of the role. We saw records for the use of medical equipment and all the staff records we viewed showed staff were competent to use the equipment. Senior staff told us the equipment they used was mostly the same as NHS healthcare providers, which was familiar to the staff.
- There was no formal system or process to track which members of staff had received an appraisal and not all staff had received a recent appraisal. The service employed 164 members of staff. Logistically, due to the geographical spread of the majority of the staff and the small number of senior staff able to carry out the appraisals, appraising each member of staff annually was unrealistic. We were told the majority of these staff only carried out a mission once or twice a year. Due to this, they remained fully mentored and supported throughout the mission. Staff were supposed to receive a formal appraisal following the completion of 50 missions for the service. However, only 10 out of 27 staff

# Emergency and urgent care services

who had completed 50 missions had received their appraisal. Due to the large numbers of staff and the limited time to carry out appraisals, the service planned to introduce some changes to the system. We were told the intention of the service was to re-appraise staff members annually as long as they completed a minimum of 25 missions within the year, since their last appraisal. Following the inspection, the service provided us with an updated human resources policy which included a flow chart identifying at what stage staff were to receive an appraisal. The policy did not identify the system or process by which the service planned to track each member of staff and their requirement for an appraisal.

- New staff had access to an induction programme. This included undertaking CPD training which included simulated practice. Each new member of staff was allocated a mentor to work with them. For their first mission they were supervised by a senior member of staff. Senior staff told us they were able to support them on more than one mission if required.

## Coordination with other providers

- There were clear lines of responsibility and accountability for the service when working on each individual mission. Staff could be responsible for just the aeromedical part of the transfer for the patient, but for other missions could also be responsible for the bed to bed transfer. This meant the clinical team would accompany and provide the clinical care for the patient in the ground ambulance from the referring hospital, right through to the arrival of the patient at planned hospital. This was requested on the initial referral form, for which the service would make the required arrangements.
- The clinical team spoke directly to clinicians caring for patients referred to them, to gain a clear and accurate presentation of the patient and their condition. Discussing the patient directly with the clinician meant the clinical team had the most accurate information to enable them to make the appropriate plans for the mission and identify any risks. The team and medical director told us at times it could be challenging to get the information required. The service would not proceed with a mission until they had the required information.
- The service liaised closely with the provider when missions referred for the contracted work faced delays

due to poor weather conditions. When this occurred, the service looked to the pilot to determine whether it was safe to carry out the mission. If this was not the case, the service would liaise with the referring hospital, the staff co-ordinating the flight plan at the receiving airport and any ground ambulance crew if required. The service would provide regular updates to the appropriate staff to keep everyone informed of changes to the flight plan. Once the pilot felt it safe for the mission to go ahead, a new flight plan would be sent to the appropriate parties via email and they would also be informed verbally.

- A large proportion of flight planning was done electronically via email. The service had a generic email account which commissioners referring patients to the service used to send referrals. This was monitored by the flight operations controllers. Quotations and flight plans were returned to the appropriate people via email. The flight operations controllers would ensure they received a response or acknowledgement following their email to ensure it had been received by the appropriate people.
- A complex mission was being arranged at the time of our inspection, which involved intricate coordination with other providers. The team were working night and day to speak directly to consultants internationally to gather the detail they required about the patient in order to launch the mission. In order to coordinate with the international hospital, the medical director had to work within the international hospital's time zone to have direct contact with consultants to coordinate this patient's care. On several occasions the medical director had conversations with international doctors at 4am, working tirelessly to make arrangements to safely bring the patient home.

## Multi-disciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. The service communicated with other providers on a daily basis to effectively plan missions referred to the service. The team told us they had good relationships with the other services and teams of individuals they worked with. Staff also felt they worked well as an extended team within the service.
- Both the aviation and clinical team worked closely together to plan missions and the care and treatment required for the patient during the mission. The teams

# Emergency and urgent care services

worked closely to co-ordinate their individual elements of the mission to enable the most direct, efficient and seamless service for the patient. The pilot had overall responsibility for the safety of the patient and clinical staff during the mission.

- Staff told us they worked closely as a team to ensure the success of the missions. Working as a team 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 the information they needed to deliver effective care to patients. Flight operations controllers had access to an electronic system to plan and coordinate the aviation side of the missions. Air operation messages were available on the screen to inform the team of situations they needed to be aware of which may interfere with the planning and timings of the mission, for example airport closures or restrictions. These messages were frequently updated via a central database. The team also added relevant information they identified from previous missions.
- There was a live flight tracking system available in the office to track the whereabouts of each aircraft at any moment in time.
- The clinical team found it challenging at times to obtain the information they needed about the patient to enable to plan a mission from a medical perspective. The team told us they would continue to make contact with the hospitals and clinicians as required until they received the information they needed. This was to ensure the clinical team were fully informed and aware of the risks of the missions and to ensure patient care was not compromised during the mission.
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. Prior to each mission, senior staff reviewed the information about the patient. This was to make sure they chose members of staff which were best able to meet the needs of the patient. These staff members were then given details about the patient and their needs both verbally and in record form.
- Staff had access to the provider's policies and procedures at the office. This also included information about each of the medical devices they had in place.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a policy available for staff regarding capacity to consent. This also included a mini mental assessment test (a test which measures cognitive impairment) for staff to use on any patients. This policy had been reviewed and updated this year. Staff would have received training at their permanent job role in the NHS, however there were plans to provide this as part of the mandatory training package due to be implemented shortly. Consent forms were used by staff on the missions regarding the flight on the aircraft. These could be signed by the patient or their next of kin in the absence of the patient's capacity. The form included a section to record any concerns or questions they had. No patients transferred by this provider which were subject to a Deprivation of Liberty Safeguard.
- Senior staff told us they did not use any form of physical restraint for any patient. They were in the process of reviewing and amending their policy as the only form of restraint that would be used was sedation. This would only be used following a detailed risk assessment of the patient's needs and if it was in their best interest.

## Are emergency and urgent care services caring?

### Compassionate care

- We reviewed 62 patient feedback forms during our inspection and five comment cards. All of these, contained positive feedback.
- Staff treated patients with kindness, compassion, dignity and respect. The comments left by patients on feedback forms included "total professionalism, respect and kindness." Other comments included "medical staff brought us back from there with such confidence and kindness just by their words and professional nursing manner. The pilot was also wonderful," "you were all amazing," "I couldn't have asked for better care." "From the moment the medical staff entered the hospital room to the end of the journey they were consummate professionals, with a human, very caring touch. The pilots also did a great job."
- Feedback forms identified how staff introduced themselves when meeting patients for the first time.

# Emergency and urgent care services

- Staff were caring, sensitive and supportive to patients' needs. Patients commented, "I haven't the words to express the gratitude and admiration I have for the wonderful medical team that repatriated my partner. They made a very difficult and worrying situation so much easier with their skilled and caring approach."

## Understanding and involvement of patients and those close to them

- Staff kept patients' families well informed about the preparation and plans for repatriating their loved ones. During the inspection, a family member of a complex patient waiting to be repatriated had the direct telephone number to speak to the medical director for the service. The medical director took a call with the family member during the inspection and provided clear information about the current position with the case, the information they required and how they planned to move forwards to be able to make definite plans for the mission. The medical director told us how important it was for the service to work closely with family members, particularly in complex situations.
- Staff kept patients and those close to them informed during the mission. We received comments from patients' family members telling us "the doctors were amazing at explaining everything to us," and "the team regularly informed my mother what was happening and what to expect during the flight."
- Staff understood the importance of looking after patients and their relatives during the mission. One patient commented that a member of staff had kept their mind occupied whilst the other member of staff looked after their loved one. Another patient had commented "staff were sensitive, supportive and kept me in the loop."

## Emotional support

- Staff supported patients emotionally during the distressing situation. One patient fed back to the team "It was like what you read about 1st and 2nd world war, when the wounded look up and two angels appear. I cannot even begin to explain the relief it meant for my wife and self. She was going down a dark road and I was there also."

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

### Service planning and delivery to meet the needs of local people

- The service had recently had its contract renewed for a further five years to provide services to a healthcare provider outside of the regulatory authority of the CQC.
- The service worked closely with the commissioners for contracted work to ensure services were planned and delivered to meet the needs of the patients. The service worked closely with the contracting provider for the contracted work to review service provision, performance and identify areas where improvements were required. The service met quarterly with the team commissioning the contracted work. Contract reviews and discussions took place about operational performance and compliance with key performance indicators. These were set agenda items. Performance reports in spreadsheet form were sent to the provider a week prior to the meeting identifying missions for discussion. Representatives from the commissioning service would also provide information to the service about missions they wanted to discuss. This enabled everyone to come prepared to the meeting. As of the next meeting in February 2018, the format and presentation of the service's quarterly performance was due to change to enable a more visual representation and better quality and depth to discussions about performance.
- There was not the same requirement for regular contact meetings for the part of the contracted referred work. Whilst the service provided aeromedical transport and a clinical team for patients from one area which referred the commissioned work, the service just provided the aircraft for patients from the other area referring the commissioned work. One of the hospitals provided its own crew when required. We were told there were between three and five occasions each month where the service would also provide a clinical team for this hospital. Discussions were held over the telephone and on the rare occasion when requested, the service would meet face to face with the team.
- Significant planning went into the mission due to the complex nature of the work, and the involvement of other services both nationally and internationally.

# Emergency and urgent care services

Intricate planning ensured the correct aircraft, equipment and medical devices were used to ensure a seamless service with minimal disruption for the patient. This ensured each mission was planned and set up to manage the individual needs and requirements of the patient.

- The service had a list of preferred independent ambulance providers which they used to carry out ground transfers. If required, the service would request a quotation. Once accepted, formal plans were made for the mission. The service also used a company with international contacts for ambulance services for any international repatriation journeys carried out. We asked how the service monitored and reviewed their preferred providers in terms of their performance and to ensure they were providing a safe, effective service for their patients. We were told they received feedback from the clinical staff on the case closure forms about staff experiences with ground ambulance crew. They would also defer to the commissioners of the mission to identify their preferred provider to be part of the mission. There was no other system to monitor the quality of performance data to ensure the quality of the service being provided by the independent ambulance provider.
- The service provided reflected the needs of the population and the requirements to match the nature of the environment. The service carried out missions for the whole population and required clinical staff with the experience of managing specific patient groups. We saw examples where missions had been carried out for babies who were days old right through to elderly patients.
- The ever increasing needs of the population were accounted for when planning and delivering services for the future. The management team were aware that it was becoming increasingly challenging to meet the needs of some patients using the service. At the time of our inspection, there were plans to better meet the needs of bariatric patients in the future.

## Meeting people's individual needs

- Services were planned to take account of the different needs of the service users and those close to them. In the patient records we examined, we saw a patient with a learning disability had been transported by the service. It had been documented the patient was not able to verbally communicate but could understand

some basic hand gestures. The patient's parent was also present to support the clinical team during the mission. Senior staff told us they would always find the most appropriate members of staff to meet the needs of the patient.

- Refreshments were provided during missions for patients and their travel companion. A senior member of staff told us they were able to cater for special diets, for example gluten free.
- Several members of the medical staff were able to support the care and treatment of patients whose first language was not English. Several members of the team did not have English as their first language. If a mission was referred to the service for a patient who could not speak English, the team would look where possible to allocate a member of staff to the mission who spoke the same language. This would enable better communication and care for the patient during the mission. The service also had a list of certified translators, external to the service which could be used to provide translation services when required, if the requirements could not be covered by the in-house team.
- Staff tried to provide continuity for patients. The team had recently moved a patient from one remote hospital to a larger, more equipped and specialist hospital in the same country to be stabilised prior to bringing the patient to a hospital in the UK. At the time of our inspection, the team were planning the final return journey for this patient and planning to use the same crew to provide continuity for the patient and next of kin.

## Access and flow

- The office was staffed and operational 24 hours a day, seven days a week to fulfil the terms and conditions of the commissioned work. During this time, the service would also receive calls, manage bookings and respond to queries from other companies looking to use the service.
- The service carried out a large number of journeys for its contracted work. Between January to November 2017, 497 missions were carried out for the contracted commissioned work. Of these missions, 27 had been delayed. Delays were due to weather conditions, bed availability, initial downgrades of urgency and re-prioritisation for a more urgent mission.



# Emergency and urgent care services

- Contracted work was carried out in line with agreed key performance indicators, including a critical response time within four hours. We were told one of the challenges was balancing and aligning the required clinical staff availability against the required response timeframe.
- Delays were communicated and co-ordinated effectively by the service. The service would ensure telephone contact was initiated and maintained with the appropriate people involved with the delayed mission. Once a new time had been identified for the mission, the flight operations controllers would create a new flight plan and provide the necessary information both verbally and by email to the required parties.
- A senior member of staff told us they were open at Christmas as a member of staff would be on call from home and an aircraft would be stationed at Birmingham airport ready to be used.

## Learning from complaints and concerns

- The service had a complaints policy. The policy covered the procedure for managing complaints, roles and responsibilities of the staff and the length of time in which the investigation was to be completed. The policy had identified a 21 day timeframe in which they would be able to provide a response to the complainant.
- The service had received five complaints between January and December 2017. All of the complaints were received from one contract referring hospital. Complaints included equipment incompatibility, communication and mission response times.
- Complaints were investigated and, where appropriate, learning was identified and actions were implemented. However, the way in which complaints were logged and reported on was unclear. Complaints about the service were identified and reported on as both a complaint and an incident, despite the information identifying a clear complaint. Responses to complaints were carried out on modified incident investigation templates and were headed both “report in response to incident” and “complaint response”. Following the inspection, we received an updated complaints policy from the service providing clarity around the identification and management of the complaints process. We were able to see how this new system was to be implemented moving forwards.

## Are emergency and urgent care services well-led?

### Vision and strategy for this core service

- The service had core values ensuring compassionate, safe and expedient medical services were provided to all patients. They aimed to ensure patient care was at the centre of each mission.
- The future vision for the service was to continue to expand the aeromedical transport business. They wanted to have an air ambulance solution for every part of the world, with footprints in other countries. A recent takeover of the organisation had enabled the service to invest in new, updated equipment and new aircraft. The directors were aware that following the period of rapid expansion, they needed to consolidate the business, ensure consistency and quality across the service and slow down for a period of time to enable other areas of the business to catch up.

### Governance, risk management and quality measurement

- The governance framework required further development to enable better oversight of clinical quality, safety and performance, to support the delivery of good quality care more effectively. Some processes needed to be formalised and carried out more regularly to provide better oversight of safety, quality, performance and any areas requiring improvement.
- The senior management team aimed to meet monthly to discuss the business. Increased demand and work pressures meant at times meetings were postponed, however were always reconvened. Extra meetings could also take place at short notice if required due to the senior management being onsite daily during the week. Meeting agendas contained set areas for discussion, which included risk management, incidents, and discussions around the previous and the forthcoming weeks’ operations. Actions arising from the management meetings were time framed and recorded on the minutes. This included a named person responsible for completion of the action and also included a due date and a completion date.
- There was a system to monitor quality and performance against specific criteria. The service maintained an electronic record of data from missions carried out for

# Emergency and urgent care services

their commissioned contracted work. Data identified the key performance indicator (KPI) response times which formed part of the contract agreement and whether this had been met. Internally, the service set themselves a more challenging KPI to ensure they were striving to achieve high quality performance delivery. Despite meeting the contracted KPI's for the previous quarter, any missions where response times were not met were highlighted and discussed at quarterly contract meetings. This meant learning could be identified which enabled improvements to be made for the future.

- The service had two systems to identify, record and manage both clinical and aviation risks, which were monitored and reviewed regularly. These were discussed and reviewed as part of the set agenda at the monthly senior team management meetings. Aviation risks were held and monitored in accordance with the Civil Aviation Authority regulations. There were five clinical risks capturing the risks to the quality of care provided for patients. These included risks around their large and dispersed workforce, remote operations, dispatch, overseas law and jurisdiction, and clinical flight staff fatigue. Each risk was scored and classified as high, moderate or low risk. Actions had been identified to mitigate the risks.
- There was no formal programme of clinical or internal audit used to monitor quality to identify areas for improvement. The flight nurse co-ordinators were responsible for reviewing medical records maintained during missions. However, these reviews were not carried out on a regular basis, nor was there any formal documentation to identify trends or themes to identify areas for improvement. Following a review of records, the flight nurse co-ordinator would email the medical director when there was a requirement for improvements in patient documentation which needed to be addressed directly with the clinician involved. Information was also routinely captured with regards to aircraft cleaning and equipment checks; however, this was not collected or used to demonstrate clinical quality or safety or to identify themes or trends to identify areas for quality improvement. Issues were identified and managed on an individual basis due to the nature of the service, and the small senior management team being heavily involved in the day to day operation of the business.

- The service had also recently reviewed one of their bespoke algorithm risk assessments to identify the effectiveness of the algorithm in ensuring patient safety during the mission. A review of the cardiac algorithm had been completed in 2017 following three years of work, with the findings demonstrating the effectiveness of the algorithm. The findings were then presented at an aeromedical conference in Turkey. At the time of the inspection, there were no set timeframes to review a further algorithm. This was costly, time consuming and not always feasible due to the high demand for the service.
- A system had been introduced two months prior to the inspection to seek the views of external stakeholders with regards to the provision of the service. Feedback forms had been developed and were being provided to hospitals on delivery of the patient at their destination hospital in the UK. A feedback form was also being emailed to other agents commissioning missions with the service, along with a summary of the mission provided routinely by the service. At the time of our inspection, no feedback forms had been returned. The medical director planned to collate and review the forms received for trends and themes, and where required make the necessary improvements.

## **Leadership / culture of service related to this core service**

- The senior management team had the skills, knowledge and experience to lead the service. The managing director had 38 years of flying experience and was a qualified examiner, whilst the second managing director and accountable officer had 28 years' experience working in the aviation industry. The medical director had over 30 years' experience working in the aeromedical industry and was a consultant in anaesthetics and intensive care medicine. The chief flight nurse was an experienced intensive care nurse and had completed advanced training under Clinical Considerations in Aeromedical Transport, an aeromedical education programme.
- The staff spoke very positively about the senior management team and their leadership. They told us all of the senior management team were approachable and they felt well supported. Staff provided us with examples of when support had been provided during

# Emergency and urgent care services

various missions. Staff spoke highly of the medical director and the chief flight nurse, telling us they were only a telephone call away and were always available to provide support and advice.

- The senior management team were visible and from time to time were exposed to front line missions. At times, members of the senior management team would make up part of various teams attending missions. Staff appreciated this and felt reassured by their presence. This provided the senior management team with a current understanding of the pressures, challenges and the events experienced by the staff during a mission.
- The culture within the service was open and honest. We spoke with staff members and the senior management team separately and both told us of the open door culture within the organisation. Staff told us they felt comfortable to report any issues and always felt supported. Staff told us the senior management team dealt with any problems quickly and described the environment as proactive to work in.
- The senior management team demonstrated an enthusiastic and proactive approach with regards to implementing actions to improve the service. During the inspection, we identified several issues which were resolved whilst we were onsite. The management team took a proactive approach following the inspection by providing us with an action plan to resolve the issues identified during the inspection, and provided us with assurance these had been completed.

## Public and staff engagement

- The service routinely requested feedback from all patients they transported. Their response rate for

patient feedback forms was 22%. Patient feedback forms were reviewed and audited by the medical director and contained 100% positive comments. The next audit was due in 2018.

- The service engaged with the staff by the provision of a bi-annual newsletter. The summer 2017 newsletter included an overview of the business and from both the aviation and clinical teams, information about the importance of incident reporting and other aviation articles of interest for the team.
- Staff told us there was an open door policy to the senior management team. Staff felt comfortable to raise issues and felt valued by the senior management team. The senior management team told us despite not seeing staff all the time, staff had direct contact with the senior managers via telephone or email and there was the opportunity at training days for them to engage with the staff.

## Innovation, improvement and sustainability

- The service had recently started to use paramedics as clinical staff for appropriate missions. There were five paramedics currently working for the service for the last six months. Paramedics were provided with the same training and competencies as the doctors and nurses. If a mission came in and the paramedic could provide the appropriate level of care for the patient they would be used to staff a mission. We were told the paramedics had also been a very useful part of the team preparing equipment for missions. The medical director told us the paramedics on the team had been the driving force behind the developments of their role and responsibilities since they joined the service.



# Outstanding practice and areas for improvement

## Outstanding practice

- The team went above and beyond to support patients and their families when planning missions. Staff worked 24 hours a day, and where necessary across different time zones to safely plan missions for patients. Family members of the patient were provided with direct telephone contact details in more complex cases. This provided the patients family with much required reassurance and keep them informed of the mission plans.
- We saw very detailed risk assessments of patients who had a number of complex needs. A number of staff had input into these and they were shared with all staff who would be involved in their care and transfer. These included all actions needed to be taken to eliminate or reduce the risk. Due to patients being transferred by aircraft staff had to make sure they had assessed all risks as any issues whilst being airborne would be very difficult to address.
- The medical director had written and contributed to the small amount of literature available to provide support and guidance in the aeromedical industry.
- Many systems and processes within the service were bespoke to meet the needs of the service and the patients using it.

## Areas for improvement

### Action the hospital **MUST** take to improve

- Establish a formal, regular programme of internal audit to monitor quality and performance and identify areas for improvement.
- Ensure all staff meeting the specified number of missions receive an annual appraisal.

### Action the hospital **SHOULD** take to improve

- Implement a system to provide better oversight of mandatory training.
- Review policies to ensure they are based on the most current legislation and guidance.
- Establish a formal process to monitor and review the quality of the service provided by their preferred ground ambulance services.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part.</b></p> <p><b>17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to –</b></p> <p>(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of the service users in receiving those services)</p> <p>There was no formal programme of clinical or internal audit used to monitor quality and to identify areas for improvement.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p><b>18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.</b></p> <p><b>18(2) Persons employed by the service provider in the provision of a regulated activity must –</b></p> <p>(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.</p>

This section is primarily information for the provider

## Requirement notices

There was no formal system or process to track which members of staff had received an appraisal and those who required an appraisal has not received this in a timely manner.