

The Great North Air Ambulance Service

Great North Air Ambulance Service

Quality Report

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Date of inspection visit: 20 March 2018
Date of publication: 05/07/2018

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Great North Air Ambulance Service is operated by Great North Air Ambulance Service. The Great North Air Ambulance Service is a charity and provides emergency and urgent care for patients across Northern and North East England. A team of doctors and paramedics deliver medical care. Clinical staff travel by helicopter air ambulance or a rapid response vehicle (RRV).

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 20 March 2018.

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

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

The main service provided by this service was emergency and urgent care.

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:

- The service was proactively engaged with initiatives to enhance patient care and develop and improve services. Staff were actively involved in developing, leading, and conducting pilot projects, research projects, audits, and teaching and training programmes. This included developing and facilitating the Pre-hospital Emergency Medicine Crew Course (PHEMCC), developing training for the police and mountain rescue, conducting a study of how the involvement of the air ambulance affected outcomes for patients, and involvement with a pilot project to develop the service for the use of blood products.
- The service had invested in a tailor-made computer system which recorded all patient contact and treatment given. The system could be used to support the auditing of clinical outcomes in order to monitor and improve service provision.
- There were processes to report, record, investigate and share learning from adverse events and serious incidents.
- There were systems in place to safeguard adults and children from abuse.
- Vehicles and equipment were appropriately serviced and maintained.
- Patients and staff were protected against healthcare associated infections.
- There were effective processes for medicines management.
- Patient care was evidence based and informed by best practice guidance.
- Staff described treating patients and relatives with compassion, dignity, and respect. Patient feedback about the service was positive.
- The service was designed to be responsive to patient needs.
- There were processes in place to receive, investigate, and respond to complaints.
- There was a clear leadership structure and comprehensive governance framework in place.
- The culture within the service was supportive. High quality patient care and continued service development and improvement was encouraged and supported by senior leaders.

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

- Risk registers did not include clear ownership of mitigating actions and dates that risk registers were reviewed.
- Not all mandatory training was up to date.

Summary of findings

- The provider had not submitted a Workforce Race Equality Standard Report.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Rating Why have we given this rating?

The main service was the provision of urgent and emergency care to injured or critically ill patients. Care was delivered by a team of doctors and paramedics. Transport was by helicopter air ambulance or a rapid response vehicle.

There were effective processes to assess, monitor, and mitigate risk. Patient care was evidence based and the service was proactive in identifying areas of development and innovation. Staff training and continued professional development was supported and encouraged. There were clear leadership and governance processes in place to support the operation of a safe, effective, compassionate, and responsive service.

Great North Air Ambulance Service

Detailed findings

Services we looked at

Emergency and urgent care

Detailed findings

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Background to Great North Air Ambulance Service

Great North Air Ambulance Service is a charity. It is an independent ambulance service based in Darlington, County Durham. The helicopter fleet, vehicles, and staff teams are based at a purpose built centre at Durham Tees Valley Airport in Darlington and at a second base in Langwathby in Cumbria. The service primarily serves the communities of Northern and North East England and covers an area of approximately 8000 square miles. This includes from North Yorkshire, to the Scottish Borders, and the Irish Sea on the Cumbrian West coast. The charity is home to three helicopters and four rapid response vehicles.

The service has had a registered manager in post since February 2016. An additional registered manager had come into post in March 2017. The service provides the following regulated activities:

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

Great North Air Ambulance Service has previously been inspected by CQC on 6 December 2011, 20 December 2012, 4 November 2013 and inspections found that the service was meeting all standards of quality and safety it was inspected against.

We carried out an announced inspection on 20 March 2018.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, three other CQC inspectors, and a specialist advisor with paramedic expertise. The inspection team was overseen by Sandra Sutton, Head of Hospital Inspection.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The main service provided by this ambulance service was the provision of emergency and urgent care by air ambulance and rapid response vehicle.

There was one registered location which had two bases. Clinical and managerial staff worked at both bases within the service. Twelve paramedics were directly employed by the service and 21 doctors worked for the service on a self-employed basis and covered shifts regularly. There was an accountable officer for controlled drugs (CDs), and lead members of staff for medicines at each base. Four pilots were regularly contracted to work at the service and were employed by an external company. The charity is home to three helicopters and four rapid response vehicles. At each base, there was one air ambulance and two rapid response vehicles. There was one further air ambulance, which was being serviced off site.

At Durham Tees Valley airport an air ambulance service was provided each day between 8am and 8pm. At Langwathby this service was provided typically between 8am to 6pm in the winter and 10am to 8pm in the summer. Times were dependent on weather conditions. The Medical Emergency Response Incident Team (MERIT) operated between 8pm and 8am on a Friday and Saturday. This service was provided on an on-call basis between 8pm to 8am Sunday to Thursday.

During the inspection, we visited the bases at Durham Tees Valley Airport in Darlington and at Langwathby in Cumbria. We spoke with 17 staff including; doctors, registered paramedics, and managers. We were unable to speak with people who used the service during our inspection. This

was because the service was providing emergency treatment and transport for critically injured or ill people. Therefore, we reviewed patient and family feedback and we reviewed five sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected three times, and the most recent inspection took place in November 2013. This found that the service was meeting all standards of quality and safety it was inspected against.

Activity (July 2017 to December 2017)

- In the reporting period July 2017 to December 2017 there were 728 emergency and urgent care patient journeys undertaken. These consisted of 450 aircraft deployments and 278 response car deployments.

Track record on safety (January 2017 to December 2017)

- No Never Events.
- 42 clinical and non-clinical adverse events. Data relates to both locations within the service.
- Two complaints.

Emergency and urgent care services

Summary of findings

We found the following areas of good practice:

- There were comprehensive processes to report, record, investigate, and share learning from adverse events and incidents.
- Staff understood their responsibilities to safeguard vulnerable children and adults from abuse. There were systems to record safeguarding referrals and also to work with other organisations to raise and log safeguarding concerns.
- The service supported staff to undertake mandatory training relevant to their role. There were systems to monitor and encourage training compliance.
- The service had effective processes to protect patients and staff from healthcare associated infections.
- Vehicles and equipment were regularly checked, maintained and serviced.
- Medicines were stored securely and appropriate records and checks were maintained.
- Staffing was planned in advance and met service needs.
- There was guidance and information for staff about response to major incidents
- Patient care and treatment was based on best practice guidance.
- Standard operating procedures were evidence based and regularly updated.
- The service was proactive in identifying ways to monitor and improve patient outcomes.
- There was a thorough induction process and there were systems for monitoring staff performance.
- Staff worked with other each other and with external organisations and agencies to provide high quality patient care.
- Staff understood their responsibilities in seeking informed consent and making best interests decisions where patients were unable to provide informed consent.
- Patient feedback about the service was positive.
- Staff described treating patients with compassion, dignity, and respect.
- Staff took steps to involve patients and relatives in decision making and to provide emotional support.

- The service provided staff with support and signposted them to external organisations if appropriate.
- Services were planned to meet the needs of local patients.
- The service monitored response times to incidents.
- The service met individual needs in a number of ways, including using translation aids to communicate with people where English was not their first language.
- There were effective systems in place to receive, record, investigate and respond to complaints.
- The service had a clear leadership structure in place. Leaders were committed to continually developing and improving the service in order to provide patients with high quality care.
- There were effective governance processes in place.
- Staff feedback was that leaders were approachable and visible. Staff reported that there was a supportive culture.
- The service sought feedback from patients and staff, and made changes and improvements to the service as a result.
- Continued learning, service development, and innovation was encouraged and supported by senior leaders.

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

- Risk registers did not include clear ownership of mitigating actions and dates that risk registers were reviewed.
- Not all mandatory training was up to date.
- The provider had not submitted a Workforce Race Equality Standard Report.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- There had been 42 clinical and non-clinical adverse events between January 2017 and December 2017. Adverse events included 11 safeguarding referrals which were logged for information only.
- There were comprehensive processes for reporting and recording adverse events and serious incidents.
- The service had clear policies and procedures for reporting adverse events and serious incidents that were available to all staff. The policies contained definitions of adverse events, which included failures of equipment, medicine, or procedures, patient safety issues, safeguarding referrals, public relations concerns and near misses. We saw that adverse events were classified according to one or more of these categories.
- Adverse events were classified and responded to as serious incidents when they related to moderate or severe patient harm. There was a separate policy relating to serious incidents which outlined procedures for investigation and escalation of notifiable safety incidents.
- Staff had access to an electronic system for reporting adverse events and serious incidents.
- Staff we spoke with were able to give examples of what constituted an adverse event and serious incident. They were aware of how to log an event or incident using the electronic recording system.
- We reviewed an adverse event reporting form from March 2018. We noted that adverse events were categorised into type of event and risk assessed. Higher risk adverse events were prioritised for immediate investigation.
- When adverse events or incidents were logged, an alert was sent to a designated senior member of staff. The senior member of staff reviewed the event and allocated a designated member of staff to coordinate the investigation.
- Staff told us that where an adverse event or incident had been reported, it was thoroughly investigated. Learning was shared with all relevant staff through the daily morning briefing, operational and clinical audit days, and by email.
- We observed two examples from the daily briefing on the day of the inspection. In one case, additional straps had been added to kit bags to attach them more securely during flight. In another case, the reasons were reviewed as to why the fire service was delayed as the air ambulance landed on the roof at a hospital.
- Staff understood the requirements of the duty of candour legislation. Duty of candour is a regulatory duty that relates to openness and transparency. It requires providers to notify patients and other relevant persons of certain notifiable safety incidents and provide reasonable support to the person.
- Policy included relevant information and guidance relating to duty of candour. Staff were introduced to the company's duty of candour policy during their staff induction process.
- The training matrix showed that all staff had received training in duty of candour within the past three years.
- All incidences of patient care including adverse events or incidents were reviewed by the clinical standards panel. This was to ensure that best practice was followed and to identify any areas of improvement or learning. The panel consisted of two doctors and two paramedics working for the service, and two external doctors. Any required actions or learning points were shared appropriately with staff.
- The management team told us that in the event of a joint investigation with a contracting service they received feedback, as required. We were told the service had good working relationships with local NHS and mountain rescue providers to enable this process.

Mandatory training

- There were procedures to plan, deliver and monitor mandatory training.
- Designated lead members of staff maintained an overview of compliance with mandatory training.
- Training was recorded on a spreadsheet which was regularly reviewed. There was a red, amber, and green rating system. This clearly demonstrated when training had been undertaken and when training updates were due.
- Staff could instantly access the training matrix online with colour coding showing where they were due, or overdue, for mandatory training. Staff told us that where mandatory training updates were due, reminders would be given in the morning briefing and by text and email to staff.

Emergency and urgent care services

- Staff received training on a range of topics, including but not limited to life support, moving and handling, infection control, safeguarding children and adults, and equality and diversity.
- Mandatory training also included specialist topics such as 'blood on board' training.
- We reviewed the mandatory training spreadsheet for paramedics. Training compliance rates were 100% for the majority of courses. One newly employed paramedic had not yet undertaken training on medical devices and safe restraint. The training lead told us that this training was being scheduled. Two staff had not completed helicopter underwater escape training by the day of the inspection. This was scheduled for 23 March 2018.
- We reviewed the training spreadsheet for doctors. This identified the different grades of doctor. It highlighted doctors who had not yet completed their competencies within the organisation and who would work with another doctor for support and continued learning until they had been assessed as competent.
- Doctors had undertaken a range of mandatory training courses. Training rates were 100% for the majority of courses. However, updates were overdue for some doctors who had been signed off to work without another doctor. One doctor had last undertaken basic life support training in July 2016 and two doctors had undertaken data security training in January 2017. The matrix showed that updates for these courses were due annually. One doctor had not completed major incident training, but had undertaken training on Joint Emergency Services Interoperability Principles. Six doctors had not completed safe restraint training for patients displaying behaviour that challenged. The training lead told us that the service was in the process of scheduling training dates for these staff.
- Staff told us that mandatory training requirements were updated when new equipment was introduced into the service. Staff completed training on the use of the equipment and an assessment of competence before being able to use it. We observed during the morning briefing at both sites that staff were encouraged to undertake training on new pieces of equipment in the office if time during day.
- All paramedics received driving under blue light training.
- Staff told us that mandatory training followed the same pathways as local NHS ambulance service providers.
- On the day of the inspection, we spoke with one of the doctors on duty. They told us that they would either access training online resources or complete at their other place of work and provide the service with a certificate.

Safeguarding

- There were appropriate processes in place to safeguard people from abuse. There was an up to date policy for staff to follow.
- The staff we spoke with gave us examples of what constituted a safeguarding concern and were able to describe the process for reporting these.
- There was a safeguarding lead with level four safeguarding training. The lead was available to provide advice to staff members if there were concerns.
- Staff received level three safeguarding children and adults training. At the time of the inspection training completion rates for safeguarding children and adults were 100%. All staff had completed training within the past three years. Staff had access to safeguarding policies for children and adults.
- All paramedics and doctors who had been signed off to work alone within the service had also undertaken further training courses to enable them to safeguard patients. For example, to enable recognition and prevention of modern slavery, female genital mutilation, and child sexual exploitation.
- Staff were required to refer their safeguarding concerns through the local NHS ambulance service referral systems. This was to ensure co-ordination with the NHS, and that concerns were subsequently raised with the appropriate local authority.
- Staff also logged safeguarding concerns through the internal adverse event reporting process. The adverse event report forms allowed staff to categorise the incident as a 'safeguarding' report. The report could then be allocated to the senior member of staff who was the safeguarding lead for monitoring and follow up.
- Safeguarding concerns were reviewed at clinical standards panel meetings. This was to ensure that any investigations were adequately supported and progressing in line with the company policy. We saw one example from a panel in 2017 where a query had been sent back to a team to explore why a safeguarding referral had not been made.

Emergency and urgent care services

Cleanliness, infection control and hygiene

- The service had effective processes to protect patients and staff against healthcare associated infections.
- The service had clear infection, prevention, and control policies, which were based on relevant guidance. Policies had been reviewed and updated in January 2018. There were policies for general areas, hand hygiene, management of sharps, waste collection and disposal, personal protective equipment, uniform, and linen.
- Infection, prevention and control training was delivered to all staff as part of their induction training and mandatory training updates. All staff had completed infection control training in the last three years. Staff discussed infection control in different scenarios to enhance learning.
- All ambulances, garages, staff areas and offices were visibly clean and tidy.
- The operational crew were in charge of cleaning the vehicles and the ambulance base. Staff followed a cleaning schedule. There were different tasks set for each day of the month. Staff signed a record to indicate when these were completed.
- Vehicles were cleaned after each job and regular deep cleans took place.
- The helicopter was cleaned at the end of each shift, or between patients, if necessary and there was a deep clean every week.
- Cleaning equipment was kept in one of the store rooms. Single use mops were used for cleaning clinical areas; separate mops were used in non-clinical areas. Storerooms were kept locked.
- We reviewed daily cleaning records for the stations and vehicles for the past month showing that the correct procedures had been completed. The provider regularly reviewed cleaning records to ensure appropriate cleaning was undertaken.
- Personal protective equipment was available for all staff. This included, for example, disposable clinical gloves, goggles, aprons, and sleeve protectors.
- Each member of staff was supplied with a hand gel dispenser which was stored in their uniform. Staff were aware of when these should be used.

- The service had a uniform policy that outlined the roles and responsibilities of all staff members. There were facilities for staff to wash their uniforms at the base. Staff kept a spare uniform at the base in case they needed to change in to clean clothes during the course of a shift.
- At the end of each shift, ambulance crews took clinical waste and sharps off the vehicles and these were placed in clearly identifiable, colour-coded and locked bins at the base. These were emptied by a private contractor.

Environment and equipment

- The bases were suitable for the purpose of the work conducted.
- Facilities included aircraft hangars, garages, equipment storage areas, offices, kitchens, shower rooms, and laundry rooms.
- We found the bases were clean and well laid out. They were well lit, tidy and fit for purpose.
- The sites were secured, preventing access to unauthorised personnel. Entry was via swipe card and identification was required for all visitors.
- There was a designated member of staff with overall responsibility for health and safety, and health and safety representatives from each base. We saw that health and safety and fire risk assessments had been undertaken in 2017. The service had contacted the organisation who had provided the assessments to provide additional information in order that risk assessments could be updated.
- There were health and safety committee meetings where required actions were identified, and completion of action monitored. There were processes to ensure that information from health and safety committee meetings was communicated to managerial and operational staff within the service.
- There were effective processes to ensure that vehicles were appropriately maintained. We observed that staff were responsible for completing a daily vehicle check before every shift. This included checking if the vehicle was in a good state of repair.
- Rapid response vehicles that were in use had valid tax and MOT in place. The MOT test due dates, servicing schedules and insurance certificates were recorded on a computer system. Alerts were generated and sent to base managers to prompt them to arrange servicing.
- The service owned the air ambulances. The air ambulances and any medical devices fitted were

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maintained by an external company. Great North Air Ambulance Service operated two air ambulances each day, but had a third which could be used in the event that another was out of action.

- There were also plans in place to review and change the aircraft fleet in response to expected changes in aviation regulations.
- The Civil Aviation Authority safety test and service due dates were recorded on a computer system. Alerts were generated and sent to base managers to prompt them to arrange servicing or renew vehicle equipment.
- There had been a Civil Aviation Authority audit within the past year. The lead pilot told us that there were no outstanding actions from the audit.
- One of the senior members of staff held overall responsibility for checking that any air ambulance servicing or maintenance had occurred. During the daily morning briefing the pilot reminded staff to visually check the aircraft before boarding. Aircraft with any faulty equipment did not fly.
- There were effective processes to ensure that there was sufficient equipment, and that this was appropriately checked and maintained.
- The service provided staff with sufficient equipment to carry out their roles.
- Essential equipment in the vehicles and on the base had been checked. We found that equipment was in order and had stickers showing the next checking date. Equipment had been safety tested and appropriately calibrated where necessary.
- Staff told us how the service acquired new equipment based on feedback from staff, audit, research, and evidence. For example, we saw that following staff feedback the service had purchased colour coded syringes. These were intended for use during the night to increase safety and reduce the risk of administration of an incorrect dose at times where there was a possibility that visibility could be reduced.
- Staff had access to equipment to provide protection when working in adverse conditions and circumstances. For example, stab vests were kept in the cars and aircrafts. Each day checks were undertaken to ensure that the vests were the correct size for the person on shift. Staff also had access to hard hats, gloves, boots, aprons, and goggles.
- During the morning briefing, staff were reminded that any loss or damage to equipment should be reported. In addition, during this staff reviewed actions taken in

relation to station, vehicle or equipment maintenance. For example, there had been a concern with the opening of a garage door that was being resolved at the time of the inspection.

- The daily briefing also included notifications of any required actions for equipment based on alerts from the Medical and Healthcare Products Regulatory agency.
- Consumable stock was stored on shelves in store rooms. The level of stock was managed by the base manager. The staff we spoke with told us there was never any problem replacing used consumables.

Medicines

- There were processes in place for the safe management of medicines.
- There were policies in place, which provided guidance on the ordering, storing, recording, administration, and disposal of controlled and non-controlled drugs.
- There were standard operating procedures for the use of specific medicines used in the service. Standard operating procedures were mapped against Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and National Institute for Health and Care Excellence (NICE) protocols. During the daily briefing, a standard operating procedure for a medicine was reviewed each day to ensure staff knowledge remained up to date.
- Senior staff told us that standard operating procedures were reviewed every two years and as needed in line with new research and guidelines. When a review or update was required, this was allocated to a specific individual to undertake. The standard operating procedure was then presented to the clinical standards panel for further review and sign off.
- Ambulances were staffed by a doctor and a paramedic. Patient group directions were in place for two medicines. Patient group directions allow paramedics to administer medicines to patients with an identified clinical condition without instruction from a medical prescriber.
- A local NHS trust supplied the medicine to the service. There was member of staff in charge of ordering new medicines. Orders were placed on a monthly basis and staff recorded new stock as it arrived.
- Medicines were stored securely in a locked stock room.
- Staff prepared blue and red packs of medicines to take with them on the vehicles; one for adults and one for

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children. Packs were checked against an inventory list and sealed with a tag until they were opened for use. The operational crew checked the status of each bag every morning.

- All medicine packs were appropriately signed in and out of the station by ambulance crews on the day that they needed them.
- Controlled drugs were locked in a safe inside the locked stock room. Staff told us that controlled drugs were also stored securely when the air ambulance was being used to assist patients. Medicines remained with crew members or were stored in the locked helicopter in view of staff. The service had a robust, electronic system of medicines management and stock control. This included accounting for each tablet given against a patient report form. Controlled drugs were also manually reconciled each day and checked against the computer record.
- Staff used an appropriate stock rotation system. We checked a random sample of medicines that were stored at the base. We found that all of these were in date.
- Some medicines were stored in a fridge to maintain them at the correct temperature. The fridge maximum and minimum temperature was checked daily by the operational crew. A record of the temperatures was kept. We reviewed the temperatures recorded in March 2018 and saw that they were within the correct range.
- We asked about actions taken when fridge temperature exceeded the recommended guidance. The base manager told us that they had sought advice about what actions would need to be taken for each medicine based on the manufacturer's guidance. They also investigated the causes of any discrepancies in temperature reading, and provided guidance to staff to reduce the likelihood of reoccurrence.
- Supplies of blood products were delivered to a key coded, locked and temperature-maintained box on site. These products were either used or returned by motorbike courier in a timely manner to ensure that the products could still be used elsewhere.
- Oxygen and oxygen and nitrous oxide were stored in a separate, lockable facility, with cylinders stored off the ground. All of the cylinders we checked were in date.
- Oxygen in self-contained cylinders was mounted on the aircraft. This system was compliant with aviation regulations and serviced by an external contractor.

- The base manager told us that the oxygen and oxygen and nitrous oxide mix was checked on a daily basis to ensure that it was in good working order. They showed us evidence related to an external contractor inspecting and servicing the equipment.
- Staff conducted medicine audits to ensure the quality of service provision and treatment. For example, an audit had been conducted in 2017 to review the use of a medicine to treat excessive blood loss. Results showed that for 74 (100%) patients medicine was administered within three hours and for 25 (34%) patients within one hour. This showed medicine was administered by staff within the three hour timescale that was linked to improved chances of survival. The results of the audit had been published in a professional journal to share learning.

Records

- The service used standardised patient record forms. These were completed for each patient who had been cared for by the service. These recorded a range of details regarding the nature of the incident, the care pathway that was followed and the types of medicines given. Each form was signed and dated by the relevant member of staff.
- We reviewed a sample of five patient records that had been completed within the past month. We found that accurate and complete records had been kept.
- Staff told us that paper records were uploaded electronically and then stored securely on a password protected IT system.
- Information technology systems enabled managers to perform monthly audits of patient record forms.
- Audit results showed that 831 patient record forms had been reviewed between March 2017 and January 2018. Results showed that 98% of these were well set out, with relevant information, including times and signatures. Records were regularly reviewed at the clinical standards panel and operational governance panel.
- Senior staff told us that patient records were retained securely for 26 years before secure destruction. The electronic system for recording patient records anonymised adult data after seven years.
- Relevant patient information was passed on from the local NHS trusts at the time of mobilisation.

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- There was a process for providing receiving services with relevant written information about patients' medical condition and treatments undertaken.

Assessing and responding to patient risk

- Ambulance operations staff were aware of the Joint Royal Colleges Ambulance Liaison Committee protocols. The provider had also developed a series of standard operating procedures for staff to follow. These were based on relevant, published guidance, including the JRCALC protocols and NICE guidance. This gave assurance that patients would be assessed against appropriate protocols.
- Staff told us that they could seek medical advice from a doctor at the other air base should this be required.
- Staff completed structured assessments and clinical observations on patients as part of their care and treatment to continually assess for early signs of deterioration. If a patient deteriorated during a transfer, crews informed the receiving hospital's emergency department so hospital staff were aware before the patient arrived.
- Vehicles were equipped to support staff in carrying out observations of patients during transport to monitor for signs of deterioration in the patient's health. For example, staff could carry out blood sugar monitoring and tests of heart functions. There was appropriate equipment for both adults and children.
- The service had a policy related to dealing with violent or disturbed patients who may pose a risk to safety during a flight. The ambulance crews assessed the risk of an adverse incident occurring and considered the use of a land based ambulance to more safely transfer a patient.
- All operational staff had undertaken training in conflict resolution in the last three years.

Staffing

- Staffing was planned in advance to meet the service needs. Twelve paramedics were directly employed by the service and 21 doctors worked at the service on a self-employed basis and covered shifts regularly.
- At Durham Tees Valley airport the service provided one air ambulance each day with a crew of one pilot, one doctor, and two paramedics. Staff worked 12 hour shifts between 8am and 8pm.
- The service had a contract with an NHS Trust to provide a Medical Emergency Response Incident Team (MERIT).

The team used a rapid response vehicle staffed by a doctor and paramedic. The service operated between 8pm and 8am on a Friday and Saturday. During 8pm to 8am Sunday to Thursday the MERIT service was provided on an on-call basis.

- The service provided one air ambulance each day from the Langwathby base. This was staffed with a crew of one pilot, paramedic and doctor. Staff at Langwathby worked 10 hour shifts typically with an 8.00am to 6.00pm pattern in the winter and 10.00am to 8.00pm in the summer.
- The shift rotas were published a month in advance. During the daily morning brief, it was checked that required staff corresponded with the rotas, online system, and diary.
- We discussed staffing levels with the base manager. They noted that staff could be used to cover shifts from either of the station bases. They had not had any problems fulfilling their rota and they had no concerns about staffing levels. No agency or bank staff were used.
- We saw that between 1 July and 31 December there was a doctor on duty for 99% of all calls where the service provided a response.
- Staff said they felt they had enough breaks and time between shifts and told us that they did not work overtime. Staff we spoke with told us that there were enough staff to provide patient care.

Anticipated resource and capacity risks

- The service had comprehensive, recently reviewed business continuity plans for each base. These included details of where plans should be located, emergency contacts, identification and assessments of risks, and control measures.
- The provider anticipated resource and capacity risks through the maintenance of regularly updated risk registers. The risks registers demonstrated appropriate identification and recording of risks associated with clinical issues, corporate issues and aircrafts.
- Weather forecasting and light conditions were discussed in daily briefings. This was to ensure aircraft safety prior to flight. Where flying was not possible teams used rapid response vehicles to respond to incidents.
- There were additional vehicles that could be used in the event of vehicle maintenance or breakdown.

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Response to major incidents

- The service had a major incident response plan which all staff could access. There were laminated action cards available to provide staff with advice about roles and responsibilities in the event of a major incident.
- Records showed that all paramedics and most doctors had completed major incident training. One senior doctor and one doctor who had not been signed off to work without another doctor had not completed the training. However, all doctors and paramedics staff had completed training on Joint Emergency Services Interoperability Principles.
- Every two months staff attended operational and clinical audit days. A recent agenda item was discussion of responses to major incidents and terrorism.
- Medical staff told us that they were working with NHS England to improve the enhanced response to major incidents. Staff told us that they had been involved with introducing a national daily air ambulance register. This allowed the National Ambulance Resilience Unit to immediately see what resources were available in the event of a major incident
- Staff told us that they had a formal arrangement with one local NHS ambulance service for responding to major incidents, and that they offered help to other NHS ambulance services as needed.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Staff followed national guidelines, which included the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and National Institute for Health and Care Excellence (NICE) guidelines, as well as the Association of Anaesthetists of Great Britain and Ireland. For example, all of their medicine standard operating procedures were mapped against JRCALC and NICE guidelines.
- Staff told us that Great North Air Ambulance Service had contributed to the development of the Association of Air Ambulances and associated guidelines. For example, we saw that one of the doctors was credited as having contributed to the Framework for a High Performing Air Ambulance Service (2013).

- Standard operating procedures covering different care pathways and treatment protocols were in place. These were reviewed and updated every two years and as needed in line with new research and guidelines. If there were any changes to the agreed protocols, staff were alerted by email and asked to electronically sign that they had read and understood the changes.
- Each day there was a medical briefing at each base where three procedures were reviewed and discussed amongst staff. On the day of the inspection, the team reviewed the responses to a brain injury, the use of a medicine and aircraft refuelling procedures.
- The service planned and delivered operational and clinical audit days every two months. This enabled the sharing of new learning and best practice with staff in line with national guidance on a range of illnesses and injuries.
- The service encouraged staff to participate in audit, research, and continued professional development. Information sharing took place internally and with other organisations to promote learning.
- The service carried out a range of audits to support the monitoring of the quality of the care provided, as well as to identify areas for improvement. For example, audits included reviewing data each month for patients who had experienced traumatic cardiac arrest, suspected fracture, and myocardial infarction.
- Staff were committed to learning and professional development in order to provide high quality care to patients.
- Staff told us that there were debriefs after each episode of patient care to ensure high standards of care were promoted and maintained and learning points identified.
- All incidents of patient care were reviewed by the clinical standards panel. This was to ensure that clinical guidelines were followed and patient assessment and treatment was based on best practice.

Assessment and planning of care

- The service was working with NHS ambulance service providers to transport patients. Typically the service treated and moved patients requiring emergency transfer by air ambulance either because a swift response was required or because the site where the patient located was more readily accessible by air.

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- Bookings were co-ordinated through an evidence-based, electronic dispatch algorithm. Staff could view information received through the NHS dispatch system to aid their planning.
- Staff had an agreement with an NHS ambulance service which allowed them listen to calls to assess what care and treatment might be required when they arrived on site. They were able to make contact with crews that were live on scene to determine whether assistance was required.
- Standard operating procedures were in place to manage specific conditions, for example brain injury.
- Regular communications took place between the clinical staff and the pilot. This meant that pilots could plan transport to an appropriate destination and staff could undertake patient care in an efficient manner.
- Staff were knowledgeable about local care pathways. They used this information in order that patients could be transported to the most appropriate destination, based on the nature of their medical condition. For example, patients with major trauma, could be transported to the nearest trauma centre and bypass local hospitals.
- The computer system enabled the recording of key time points in each patient's journey. A computerised system logged when a call for the service was received. This record was subsequently kept up to date by staff calling in to the control base.
- The response times were monitored against key performance indicators. For example, there was a target of having the ambulance airborne in under five minutes from receiving the request.
- The clinical standards panel reviewed every patient record form to check whether or not outcomes could have been improved.
- The service had introduced the use of body-worn video cameras for learning and debriefing. Protocols for use had been developed with the Surveillance Camera Commissioner to ensure patient dignity and confidentiality was protected. Staff ensured that consent was sought and where this was not possible decisions were made in patients' best interests.

Response times and patient outcomes

- Patient outcome information was limited due to the nature of the service. Clinical staff would hand over a patient to a receiving service, and would not always receive information about outcome.
- The service had been involved in a recent study of how the involvement of the air ambulance affected outcomes for patients. The results showed that patients who had received assistance from the service were less likely to require critical care interventions in hospital. Results also showed that patients who had been assisted by the service were less likely to experience long-term effects of injuries than patients who had not been assisted by the service.
- The service reviewed clinical performance against a number of quality performance indicators. Figures were reviewed on a monthly basis at the clinical standards panel and trends were reviewed over the year. For example, results showed that 100% patients had received appropriate treatment for major haemorrhage from February 2017 to January 2018.
- There were processes in place to ensure recruitment of staff with appropriate qualifications and experience. The human resources department maintained records of recruitment documentation, for example Disclosure and Barring Service checks, checks of professional registration, and references.
- Training was actively encouraged and promoted by senior managers. Staff were passionate about continued learning in order to provide patients with high quality, evidence based care.
- We saw that there was a comprehensive induction training package. Staff worked through a training booklet that took, on average, six months to complete. This covered aviation and clinical skills.
- There was a process to assess competency before staff were signed off to work as a full member of the team. This involved a test and sample clinical scenarios.
- We observed that the training matrix was being developed to include clinical competencies. This was so that the service could monitor that staff kept competencies up to date through live and / or simulated practice.
- All paramedics received blue light training. The human resources department kept copies of driving licences. Staff completed an annual driver declaration form. These were reviewed to ensure that all staff who drove within the business were fit to drive.

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- Staff who drove the tractor at the airport were required to have an airport driving license and watch a recording explaining the road markings at the airport. Staff would then practice driving the tractor when the aircraft was not attached and only drive the tractor when they felt confident to do so.
- The service was an accredited training unit for doctors undertaking specialist training in PHEM. The service reported that all doctors and paramedics working at the service were supported to do the Pre-hospital Emergency Medicine (PHEM) crew course in aircraft competencies so they could assist the pilot with specific duties. Two doctors were being supported to undertake speciality training in PHEM at the time of the inspection. In addition, the majority of doctors and paramedics had completed helicopter training, including underwater escape training.
- Staff told us that they were supported and encouraged by senior managers to achieve postgraduate qualifications such as diplomas and masters qualifications relevant to their role. Staff were also encouraged to attend conferences and learning events and feedback learning to staff to share knowledge.
- Staff attended a training and review day every two months to promote learning. We reviewed a training day agenda which covered trauma audit, clinical advice on thoracotomy, and responses to major incidents and terrorism.
- There was a process for reviewing staff performance and learning needs. Doctors undertook appraisals with the medical director. We saw a list of documents that doctors were required to send to the appraiser one week before appraisal due. This included a General Medical Council certificate, personal development plan, mandatory training log, details of teaching or training provided, and attendance at continued professional development events.
- We were told that paramedics undertook quarterly 'one to ones' with senior staff to monitor performance and identify learning needs. Staff told us that a performance analysis process was being introduced for paramedics. This would involve performance being assessed against clinical and operational standards and feedback from colleagues.
- Staff performance was reviewed as part of the operational governance panel. Reviews took place two months before appraisal. Following this, a summary and

action plan was recorded for each staff member. This was then discussed with each clinician at appraisal and used to form a personal development plan.

Coordination with other providers

- Staff regularly communicated with other providers in order to coordinate patient care.
- Senior members of staff met quarterly with representatives from two local NHS ambulance trusts to share feedback and identify ways to facilitate joint working.
- Staff regularly liaised with ambulance services, police, fire brigade, mountain rescue, coast guard and other agencies to coordinate responses to incidents.
- We met with representatives from the Lake District Search and Mountain Rescue Association. They told us that they had clear and positive working relationships with the service.
- Staff showed us that they had jointly developed a safety training video to help the mountain rescue staff understand how to work safely around the helicopters.
- We observed a call from the joint 'Search and Rescue' call system come in. This simultaneously alerted all of the relevant care providers, including mountain rescue, NHS ambulance trusts and Great North Air Ambulance Service. The services were able to co-ordinate their response using this system.
- Staff described they had developed and delivered an advanced first response training package for the police. This enabled firearms police to administer care to injured parties in areas that were not immediately accessible to medical staff due to ongoing risk.
- The service had been involved in establishment of the Northern Trauma Network. Staff described awareness of specialist regional trauma centres. They worked with relevant providers to ensure patients were transported to the most appropriate location to receive treatment. Staff contacted receiving hospitals to provide advance information about patient condition so that arrangements could be put in place for medical care.

Multi-disciplinary working

- Members of the clinical and non-clinical teams worked effectively together. They maintained clear lines of communication to facilitate multi-disciplinary working.

Emergency and urgent care services

- Clinical staff and pilots described good working relationships with clear lines of accountability and communication.
- Staff assisted NHS ambulance teams during incidents with medical interventions.
- Staff provided comprehensive patient handovers to health professionals at receiving organisations. For example, these included details of injuries, observations, treatments, and safeguarding information if appropriate.

Access to information

- Due to the nature of the services provided, staff did not routinely have access to notes that provided specific information about a patient or 'do not attempt resuscitation' orders.
- Patient information was passed on from the local NHS trusts at the time of mobilisation.
- Staff told us that they would ask patients or family members for relevant information.
- The crew used a hand held tablet, which included a navigation system that was constantly updated. During the daily briefing staff received updates from the pilot relating to weather conditions, flying hours, and notices of any potential hazards that may affect flying conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act (MCA) and Mental Health Act. At the time of our inspection, 100% staff had received this training. Staff understood their responsibilities in relation to consent and decision making according to legislation.
- Staff sought informed consent from patients prior to treatment. Staff respected patients' decisions about their care. For example, if a patient did not want to travel by air, they could arrange for a land transfer, where practical.
- Where appropriate, staff conducted MCA assessments for treatment decisions. They did this by assessing patients' capacity to understand, retain, and weigh up information, and communicate a decision.
- Staff made best interests decisions for patients who were unable to consent due to injury or being unconscious. We saw that there were forms on board the ambulance for recording best interest decisions.

- Staff told us that in cases where they needed to act in a patient's best interest, they opted for the most limited or minimally invasive, but effective procedure.
- Staff said that it may not always be possible to communicate all possible treatment options to the patient when making urgent decisions in emergency situations. Staff reported that, they always kept the patient informed about what was happening and obtained verbal consent wherever possible.
- The consent policy provided guidance relating to children and adults.

Are emergency and urgent care services caring?

Compassionate care

- Staff showed an awareness of the importance of maintaining patients' privacy and dignity. For example, staff told us they ensured that patients were covered with blankets wherever possible.
- Staff described additional measures that were taken to preserve patients' privacy and dignity. For example, asking police to cordon off areas and asking crowds to move back.
- Staff emphasised the need for talking with patients and relatives politely and using jargon free language.
- Measures were taken to ensure confidentiality, such as ensuring that personal information was discussed out of earshot of others.
- The service had conducted a patient survey for 2016 to 2017. Thirty two patients responded (50% response rate). Results were that 100% of the 29 patients who could recollect care provided said that the ambulance crew attempted to reassure them and put them at ease.
- Patient survey results showed that patients who could recollect events and in need of pain relief were offered pain relief when required and pain was dealt with effectively.
- All of the staff we spoke with during the inspection showed a commitment to providing the best possible patient care.
- Staff told us that they sometimes received requests from patients to come to the base to give feedback and talk about what happened. They said that they supported patients to make these visits as patients frequently reported that it was helpful.

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Understanding and involvement of patients and those close to them

- Staff demonstrated an awareness of involving patients, and their relatives or carers, in decisions that were made about their care.
- For example, they told us that if relatives were unable to travel on the air ambulance, they made efforts to ensure that relatives or carers were escorted by police to the correct hospital.
- Staff told us that they shared information about what was happening with patients and carers as they were attending to the patient.
- Staff told us that they explained treatments in a way that patients could understand.
- In the 2016 to 2017 patient survey 100% of patients who could recall treatment said that the ambulance crew acted professionally, introduced themselves, described what they planned to do.
- When patients deteriorated and there was a possibility of death staff talked to the relative about the possibility of this outcome.

Emotional support

- Patient feedback indicated that crews had responded in a compassionate and supportive manner.
- Staff described supporting injured patients and relatives during distressing events.
- Staff described allocating one member of staff to speak with, comfort, and support carers and relatives where possible.
- Staff also described enlisting the help of other services such as the police and ambulance service where present. This was to support relatives, by comforting them and conveying them where it was not possible to convey them with the patient.
- Staff discussed one example where they were dealing with a deteriorating patient in presence of a carer. The patient passed away and the crew sought permission to transfer the patient to an alternative location within the home to ensure that their dignity was preserved following their death and to show compassion for the family.
- Staff told us that patients often asked to visit the base to discuss what had happened to them because of being unable to remember events. Staff arranged for patients to visit the base and reviewed what had happened with patients to support their recovery.

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

Service planning and delivery to meet the needs of local people

- The service was a charity. At the time of inspection, the service worked closely with three NHS ambulance trusts. This was to provide emergency response for treating and transporting patients in the air ambulance.
- Two air ambulances covered the North of England. One ambulance was based on the east coast and one on the west coast.
- The service also had an NHS contract to provide a Medical Emergency Response Incident Team (MERIT).
- The service also used rapid response vehicles to assist patients at times of diminished light and at places where helicopters could not fly. The service described measures they were taking to review and continually assess how this MERIT service could expand to best meet patient need.
- The staffing levels, shift patterns and availability of vehicles were maintained in line with the NHS contract's requirements.
- The management team told us they had meetings with representatives from the NHS providers to review the services that Great North Air Ambulance Service were providing.

Meeting people's individual needs

- The primary focus of the service was to provide life-saving treatment. All doctors and paramedics had undertaken equality and diversity training.
- There were a range of measures in place to ensure that staff could meet patients' needs.
- Staff carried books designed by another provider that had translated key information and questions in a range of different languages. The aim was to support communication with people for whom English was not their first language.
- Staff also used language translation applications on their tablet computers.
- Staff commented that communication in the helicopter was difficult due to noise, but that each patient was supplied with headphones to overcome this problem.
- Staff told us that the service could not transport the majority of bariatric patients by air due to weight and

Emergency and urgent care services

space restrictions. However, they made sure that staff were available to provide emergency treatment, and then arranged for a land transfer to hospital, if necessary.

- The staff we spoke with commented that relatives and carers were actively encouraged to accompany individuals who may require additional support on flights, for example individuals with learning disabilities or children.
- The service did not routinely transport patients under section 136 of the Mental Health Act unless there was a medical need. Patients with mental health difficulties were assessed on an individual basis to determine the safest method of transportation and treatment.

Access and flow

- The service worked closely with NHS ambulance and hospital services to determine access and flow arrangements.
- There were two operational air ambulances each day. A third air ambulance was available in the event that one aircraft became non-operational.
- There were cars at each base that could be used to transport staff to the scene of incidents to provide treatment.
- A designated member of staff at the service was responsible for identifying calls most appropriate for air ambulances. There was guidance as to the most appropriate calls for air ambulances and for dispatch arrangements.
- The air ambulance was prioritised for admitting patients to hospital. This was because of the likely severity of the patient need, but also because NHS providers were conscious of freeing up the vehicle for other calls. Therefore, the air ambulance crew could both provide emergency care and treatment during transfers, and be confident that their patients would be promptly treated at handover points.
- Service staff were aware of landing sites for the air ambulance. The service worked closely with NHS ambulance trusts to arrange transfer of patients from landing sites to receiving hospitals where appropriate.
- The air ambulance had set performance targets in relation to response times. Targets were monitored by the senior leadership team. The provider monitored

response times at each stage of responding to a call. Staff and leaders were committed to identifying ways that assistance could be provided as quickly and efficiently as possible.

Learning from complaints and concerns

- The service had effective processes in place to receive, record, investigate, and learn from complaints. Staff had access to a policy for complaints. We reviewed this document and found it contained guidance for all staff of the actions to take in the event of a complaint.
- From January 2017 to December 2017, the service had received two complaints. We reviewed these and saw records of appropriate actions that had been undertaken in timely fashion.
- Complaints could be made in person, by telephone, email, post, or on the website.
- The service's website provided contact information for patients and the public on how to provide compliments or complaints about the service received.
- Complaints were recorded electronically with responsibility for investigating the complaint allocated to a specific member of the senior management team.
- The senior member of staff reviewed complaints. A decision was then made as to whether they should also be logged and reviewed as adverse events or serious incidents.
- Complaints investigations were reviewed by either the clinical standards panel or the operational governance panel, as appropriate. Panels could request further information and also determine action points for staff. Decisions would also be made about whether any company-wide improvements could be made.
- Changes to policies or protocols made as a result of a complaints investigation were disseminated to staff via email and discussed during the daily briefing.
- The ambulance trusts that the provider worked with forwarded information about any complaints they received in relation to the care provided by Great North Air Ambulance Service.
- The policy stated an acknowledgement would be sent to patients within 14 working days of receiving the complaint. An investigation would follow and a full response was provided to patients within 28 working days.

Emergency and urgent care services

Are emergency and urgent care services well-led?

Vision and strategy for this core service

- The service's vision was to 'provide a world class pre-hospital care service for the people of the region'.
- The service values underpinning the vision were to; 'make the care and safety of patients its first concern', 'deliver world class patient service through a skilled and committed workforce', 'extend and constantly improve emergency pre-hospital and inter-hospital critical care', and 'act with integrity at all times and ensure quality in all that is provided'.
- The provider had a set of core values that were displayed on the service's staff intranet site. These stated that the care of patients was their first priority and that they would work with integrity, provide a high-quality service, ensure that they were responsible and accountable if anything went wrong, and that they would strive to continually improve the service. Staff were aware of the vision and values of the service and how they contributed to them.
- There was a strategic plan in place, which was due to be completed by 2020. The chief executive officer stated that the plan had been presented to the board of trustees to ensure that the aims of the service were viable.
- The service had identified new areas of unmet need in the locality and had developed operational and financial plans in order to provide a service that met this need.
- Staff and trustees were invited to attend away days to help plan the provider's strategy. The last occurred in 2016 to discuss the plan up to 2020. There was another away day planned for late 2018 or early 2019 to discuss what they could put in place as a strategy after 2020.
- A range of meetings were held with trustees, senior managers, and operational staff where progress with the strategic plan was monitored at a clinical, operational, and financial level.

Governance, risk management and quality measurement

- There were effective governance processes in place. There was a governance framework in place with

associated meetings, staff policies, and protocols. These frameworks and procedures were well understood by staff as they were regularly reviewed as part of the daily briefings system.

- There were operational governance panel meetings every two months. These were attended by senior staff and provided a forum for staff to discuss the operation and performance of the service. The service was reviewed in relation to a range of performance indicators, standards, and guidelines.
- A range of further meetings took place to support specific areas of service delivery. For example, meetings were held in relation to information governance and health and safety.
- There were monthly clinical standards panel meetings. These were to ensure that episodes of patient care were based on best practice. The clinical standards panel consisted of internal medical staff and also had input from external doctors to ensure a proper review of standards. Every patient record form was reviewed by the panel to identify if improvements in care could be made.
- We reviewed the minutes of the clinical standards panel meeting in December 2017 and 74 patient record forms were reviewed. The panel agreed feedback to staff which consisted of praise and positive feedback as well as areas for clarification and learning.
- There was a system for ensuring that policies were updated and reviewed. All of the clinical policies were assigned to an individual doctor from within the organisation. The policies were then submitted to the clinical standards panel for approval prior to wider dissemination among staff.
- There was an operational and clinical audit day every two months and this was attended by all staff. Agenda items and actions were regularly reviewed and monitored. Meetings included discussion of service development, training, equipment, audits, and standard operating procedure updates.
- There were systems in place to ensure that information identified in meetings was appropriately shared with staff and relevant actions undertaken. Designated staff were responsible for ensuring that relevant information was documented and shared between meetings with leaders, managers, and operational staff as appropriate.

Emergency and urgent care services

- We saw that actions identified in meetings were implemented by staff. For example, at the team brief we saw that staff were reminded to complete information for a nausea and vomiting audit identified on one of operational and clinical audit days.
- The service had risk registers which demonstrated appropriate identification and recording of risks associated with clinical areas, corporate issues and aircrafts. However, registers did not always include clear ownership of mitigating actions or dates that risk registers were reviewed. We saw that risk registers had been recently updated in response to discussions in meetings.
- Staff told us that clinical information and patient safety alerts were received from external organisations, such as the NHS central alerting system and the Medicines and Healthcare Products Regulatory Agency (MHRA). Alerts were reviewed in order that required actions could be undertaken promptly.
- The service told us that they had agreements to share outcome and monitoring data with two local NHS ambulance services as part of memorandum of understanding. The service also shared monthly trauma data with the Northern Trauma Network. Staff at the service told us that they were developing a system to receive trauma data from the Northern Trauma Network. The aim was to measure the effectiveness of tasking by reviewing information about incidents that the service did not attend.
- The service had been audited by an external organisation. The report from this organisation indicated that the service had appropriate governance systems in place to ensure quality management.
- Staff described measures that they took to provide accessible information and communications to patients who may have communication difficulties or where English was not their first language. When patients were transferred to the care of other providers staff provided information about communication needs to receiving staff as appropriate.
- The service had not developed or submitted a Workforce Race Equality Standard (WRES) report. NHS England states that implementing the WRES is a requirement for NHS healthcare providers, including independent organisations.

Leadership of service

- The service had a clear leadership structure in place. A chief executive officer led the service, and answered to a board of trustees. We found the service was well led.
- The executive board consisted of clinical and non-clinical staff in roles including, but not limited to; medical director, chief medical officer, director of operations, clinical directors, head of human resources, training leads, and information governance leads.
- There was a period of structural reorganisation in 2016 which introduced a new governance structure and promoted some staff to leadership roles from within the organisation.
- Leaders were experienced, knowledgeable and showed enthusiasm while performing their roles. The leaders in the service were clearly visible and accessible to other members of staff. The majority of the management team were also registered paramedics who remained operationally active so that they understood the day to day workings of the front line service.

Culture within the service

- There had been a period of organisational change starting in 2016. This was instigated in response to some negative feedback from staff regarding the culture of the service and the negative impact this was having on staff morale.
- The staff we spoke with were positive about the changes and commented that the service actively encouraged staff to speak up and challenge each other about the quality of the service in a positive way.
- Staff told us that the organisation had a supportive culture which emphasised learning and continued improvement. Staff felt listened to and saw examples of ideas being implemented where these would benefit patient care.
- Staff said that they felt valued, and that the relationships between staff at the organisation were honest and supportive. Staff told us that crews would debrief after every job to review the patient care provided, and to provide each other with support.
- We saw that the service encouraged staff support. One staff member told us that leaders and colleagues were committed to enquiring after staff wellbeing and taking steps to support staff who may be experiencing difficulties. There was a culture of continued learning, openness, and honesty.

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- Emotional wellbeing was discussed during the operational and clinical audit day. Staff could access confidential counselling or advice sessions and there were staff wellbeing noticeboards which provided information about sources of support.
- All paramedics had completed stress awareness training in the past year as part of mandatory training.

Public and staff engagement

- The service proactively sought engagement with the public and the service website contained information for the public.
- Patient feedback was received through the service's website and by post. We saw that complaints, compliments, and feedback forms were reviewed. The service had received 45 compliments from patients between January 2017 and January 2018 about the service provided. We observed several letters and thank you cards displayed on notice boards in the staff offices.
- In the patient survey for 2016 to 2017, all patients who responded stated that they would rate the service received as 'very good'.
- The service was in the process of developing a patient follow up and feedback team. This team would be developed to liaise with patients who had received treatment and encourage patient feedback in order to monitor improve outcomes and service quality.
- The management team told us that patients regularly contacted the service to discuss the care they had received. They showed us how this was booked into the base's calendar to ensure that staff were available to support the visit. They noted that patients often wanted to explore what had happened to them or provide feedback.
- The service proactively sought staff feedback on the service. Staff surveys had been conducted in 2016 and 2017 to elicit staff views on the service. Staff described service developments and organisational restructuring undertaken in response to the 2016 survey.
- An action plan had also been developed based on staff feedback in 2017. This identified clear actions with allocated responsibilities for fulfilment. We saw examples of actions that had been undertaken, such as providing staff with further information on sources of emotional support.

Innovation, improvement and sustainability

- Innovation and improvement were core values. We observed a number of examples that demonstrated the provider's commitment to continuous improvement.
- The service had been involved in a study of how the involvement of the air ambulance affected outcomes for patients. The results showed that patients who had received assistance from the service experienced improved outcomes in a number of areas.
- Study results showed that some patients were not being identified who could benefit from the service. This led to the introduction of a system whereby staff from the service could quickly speak directly to the person calling for assistance to obtain more information.
- The service had been involved in a pilot project to develop a service for the use of blood products, including fresh frozen plasma to aid blood clotting on air ambulances. This had led to a change in practise which was now fully implemented into the service. The service had evaluated the impact of the changes and demonstrated that from the first 60 transfusions given, a third were identified as having been of critical importance to survival.
- The service had invested in a tailor-made computer system that recorded all patient contact and treatment given. It could also be used to record incidents, complaints, meeting records, and be used to support medicines management. The service aimed to become a 'paper-free' environment through developing the system to include patient report information. The existing system could already be used to support the auditing of clinical outcomes because paper records were being manually entered on to the records system.
- The service was an accredited training unit for doctors undertaking specialist training in pre-hospital emergency medicine (PHEM). The service had a lead role in developing and facilitating the Pre-hospital Emergency Medicine Crew Course (PHEMCC).
- The service had developed an electronic application in conjunction with the trauma network. This was not yet in use, but would provide ambulance crews with a reminder to ask for the service. Staff told us that this was developed as data showed that ambulance crews were in attendance at the scene for a long time before calling the service.

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- Staff had been involved in the introduction of a national daily air ambulance register. This would enable the National Ambulance Resilience Unit to immediately determine available resources to assist with major incidents
- The service had developed and taught an advanced first response training package for the police. This enabled firearms police to administer care to injured parties in areas that were not immediately accessible to medical staff due to ongoing risk.
- There were plans to upgrade its buildings and facilities. This was to reflect the expansion to the service that had occurred over recent years and to allow for adequate space for additional growth.

Outstanding practice and areas for improvement

Outstanding practice

- Staff demonstrated a strong commitment to deliver the best care possible. The service actively promoted continued learning and development, both internally and for external agencies. The service was an accredited training unit for doctors undertaking specialist training in pre-hospital emergency medicine (PHEM). The service had a lead role in developing and facilitating the Pre-hospital Emergency Medicine Crew Course (PHEMCC). All doctors and paramedics at the service had undertaken this course. The service had developed and delivered training packages and courses for a range of agencies including the police and search and mountain rescue.
- The service was committed to monitoring and improving patient outcomes through research and audit. The service had been involved in a study of how the involvement of the air ambulance affected outcomes for patients. It had also been involved in a pilot project to develop a service for the use of blood products. Both studies showed that the care provided by the service provided benefits to patients.
- The service had invested in a tailor-made computer system which recorded all patient contact and treatment given. The system could be used to support the auditing of clinical outcomes in order to monitor and improve service provision.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should revise risk registers so they include clear ownership of mitigating actions and dates that risk registers were reviewed.
- The provider should ensure that all mandatory training is up to date.
- The provider should submit a Workforce Race Equality Standard Report.