The Air Ambulance Service

Warwickshire & Northamptonshire Air Ambulance & Children's Air Ambulance

Inspection report

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Date of inspection visit: 24 August 2023
Date of publication: 08/03/2024

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

Ratings

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

Summary of findings

Overall summary

This service had been inspected before but not rated. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had the right skills and experience to provide good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- All staff were actively engaged in activities to monitor and improve quality and outcomes (including, where appropriate, monitoring outcomes for people once they have transferred to other services). Opportunities to participate in benchmarking and peer review were proactively pursued. Outcomes for people who use services were positive, consistent, and regularly exceeded expectations. Staff took part in community initiatives with other providers to reduce the incidences of knife crimes.
- The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.
- People were truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally. Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Outstanding ☆	The service had been inspected but not rated before. We rated it as outstanding. See the overall summary for details.

Summary of findings

Contents

Summary of this inspection

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

Warwickshire & Northamptonshire Air Ambulance & Children's Air Ambulance service is located on the airfield at Coventry Airport on the outskirts of the city of Coventry. It operates a critical care emergency service for the counties of Warwickshire and Northamptonshire and surrounding areas. It also has a base at Derbyshire, Leicestershire and Rutland.

The registered provider with CQC, The Air Ambulance Service, is a charitable trust established in 2003, operating from HQ in Rugby, Warwickshire. It operates across a geographical area of around 3,850m^2 and completes around 10 missions by helicopter each day with an average response time of around 13 minutes. In 2023, the organisation reached the milestone of 50,000 missions undertaken.

At the Coventry Airport site, the service operates an air ambulance helicopter which flies in daylight hours and safe weather conditions, and a Rapid Response Vehicle (RRV) which operates during nighttime hours and when the helicopter is offline. The service employs doctors and critical care paramedics trained and experienced in critical care medicine, trauma, surgical procedures and anaesthesia. The service operates under separate Service Level Agreements with 2 local NHS ambulance trusts and provides emergency care and treatment to adults and children of all ages.

The service is registered to provide diagnostic and screening procedures; surgical procedures; transport services, triage and medical advice provided remotely; and treatment of disease, disorder or injury. The service has a registered manager who has been in post since 2015. The service was last inspected in 2017 (published 2018) and this was before CQC had the power to rate independent ambulance services. There were no legal requirements placed in the service at the last inspection. This most recent inspection comes with CQC's power to rate the service.

How we carried out this inspection

We gave the provider 48 hours notice of our inspection. This was to ensure that vehicles and staff would be available while we were at the service. We inspected this service using our comprehensive inspection Urgent and Emergency Care core service methodology. The inspection team included a CQC inspector, a CQC senior specialist and a specialist advisor with experience as a trained and practicing paramedic. The inspection was overseen by Charlotte Rudge CQC deputy director of operations.

During the inspection we reviewed a range of documents related to running the service including training and governance reports. We reviewed patient records. We spoke with 6 members of staff including the registered manager. We also spoke to 2 stakeholders and 7 people or their families who had used the service.

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

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. This included academic publications and research studies, such as blood administration and calcium point of care testing.

Feedback from people who use the service, those who are close to them, and stakeholders was continually positive about the way staff treat people. People told us staff went the extra mile and their care and support exceeded their expectations. Peoples' emotional and social needs were met as much as their physical needs. Patients and relatives consistently said the support they had received had had a big impact on their recovery and coming to terms with loss.

People's emotional and social needs were seen as being as important as their physical needs. The service went above and beyond to engage with patients and relatives after they had left the service and offer support and guidance.

People's individual needs and preferences was central to the delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. People received care which was personalised to their specific needs and wants.

Staff were passionate and proud of the organisation as a place to work and spoke highly of the open and reflective culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

The service was an important part of its community. It developed community links to reflect the changing needs and preferences of the people. Initiatives included open days at the air base, health promotion and supporting former patients to share their experiences and journey with others.

The service worked on public and preventative health. For example, the service developed a knife crime initiative in response to the increase in knife crime in the local area. This helped young people to make informed decisions and actions in the hope they would be less likely to carry knives.

The service supported timely access to defibrillation, as well as community cardiopulmonary resuscitation training for the public, meaning collapsed members of the public could access important lifesaving treatment as quickly as possible.

Governance was well-embedded into the running of the service. There was a strong framework of accountability to monitor performance and risk leading to the delivery of demonstrable quality improvements to the service. Leaders and managers see this as a key responsibility.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	☆ Outstanding	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Overall	☆ Outstanding	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding

Outstanding ☆

Patient transport services

Safe	Outstanding ☆
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Is the service safe?

Outstanding ☆

Mandatory training

The service provided mandatory training in key to all staff and made sure everyone completed it.

All staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. There was a mandated training course in equality, diversity and inclusion and we were told this was updated regularly to adapt to new information or changes in legislation.

The service used accredited online training which was agreed by the Clinical Governance Group which is chaired by the service's Clinical Lead. Training was conducted over the course of a year dependent on how often the course needed to be updated, and staff were given working time to complete the training. When a module was completed, the manager would review the certificate and if all was in order, it would be signed off for that member of staff for the duration of the validity of the training. New staff were required to undertake all mandatory training as part of their induction.

Records showed that between 94% and 100% of paramedics and doctors had completed mandatory training in blood training, equality and diversity, infection prevention and control, risk management, and supporting autistic people and people with learning disabilities.

Staff undertook emergency 'blue light' driver refresher courses. The mandatory 5-year assessment was completed by dedicated 'blue light' driving instructors employed by a nearby NHS ambulance trust. This assessment was completed in the rapid response vehicles used by the air ambulance service so a realistic assessment could be made. In addition, a driving refresher course was undertaken every 2 years... Extra training was undertaken for all emergency drivers within the service. During the introduction of new rapid response vehicles in 2021 the service introduced additional training on the new 'Direct Shift Gearbox' (DSG) for all blue light driving trained staff. This training optimised the new gear box safely whilst driving under emergency driving conditions, often at night.

Safeguarding

Outstanding ☆

Patient transport services

There are comprehensive systems to keep people safe, which take account of current best practice. The whole team is engaged in reviewing and improving safety and safeguarding systems.

All staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. People who used the service were at the centre of safeguarding.

Clinical staff undertook safeguarding level 3 training for both adults and children. This was in line with the Intercollegiate guidance for Safeguarding Children and Young People: Roles and competencies for Healthcare Staff and Adult Safeguarding: Roles and competencies for Healthcare Staff. Of the 62 eligible clinical staff, 100% had completed level 3 training in both adult and children safeguarding. Due to the Service Level Agreements with the NHS ambulance trusts, safeguarding referrals were made through those NHS trust established channels and not directly to local authorities or other agencies as required. Staff were aware of safeguarding principles and how to raise safeguarding concerns directly with the local authority if needed.

A dedicated safeguarding manager for the service reviewed national safeguarding requirements regularly to ensure any changes to guidance were identified and escalated. They shared updates through the service clinical and operations committees as part of the service governance process.

An automated alert was sent the safeguarding lead for the service of when a safeguarding referral was made. The safeguarding lead contacted the relevant ambulance service where the referral was made to confirm which local authority it was made to and whether it had been received.

Pilots and non-medical staff within the service were trained to level 2 safeguarding adults and children. Of the 12 eligible staff members, 92% (11) had completed this training. In addition, staff were able to access a level 4 safeguarding trained member of staff for advice and guidance through the local NHS ambulance trust, 24 hours a day 7 days a week.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

All vehicles and staff areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records of the premises and vehicles were up-to-date and demonstrated that all areas were cleaned regularly. The service employed a dedicated cleaner with a clear set of guidance to follow and infection prevention and control training.

At the time of the inspection deep cleaning was completed by an operative in-house. The third-party cleaning company are to commence from January 2024, and they will also complete pre and post ATP (Adenosine Triphosphate) swabbing to test the effectiveness of deep cleans.. This included the wide range of equipment carried by the RRV and helicopter. All equipment would be removed before the vehicles were deep cleaned, and then cleaned before being restored under close supervision to the RRV or helicopter.

A review of the previous 3 months cleaning audits showed that premises, equipment, and vehicles had consistently scored over the provider's target of 90% compliance.

A service level agreement was in place for surgical packs for thoracotomy to be collected and autoclaved. A thoracotomy is a surgical procedure in which a cut is made between the ribs to see and reach the lungs or other organs in the chest or thorax.

Staff followed infection control principles including the use of personal protective equipment which was widely available for staff to use. Staff knew how to respond in the event of needlestick injuries or incidents involving splash of bodily fluids and had access to standard operating procedures.

Environment and equipment

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

The service had enough suitable equipment to care safely for people. The service operated from premises at Coventry Airport and comprised of staff offices, some clinical storage areas, a large training room and a rest area for staff. Vehicles included the air ambulance and a critical care car. The helicopter was stored in a hanger on site when offline.

The premises were airside at Coventry Airport and were secure from unauthorised access. Visitors were met at the entry gate and escorted on site and always supervised.

Staff were fully trained in the use of the varied range of equipment carried on the RRV and helicopter. Some of this equipment was for life-saving procedures and surgical procedures carried out at the scene. Emergency equipment was checked daily, and records showed regular testing of equipment was carried out as planned.

We observed the take off flight of the air ambulance helicopter and saw staff complying with required safety checks, including standing safely away from the helicopter when starting, and only boarding when given the all-clear by the pilot. Staff wore personal safety equipment when travelling by helicopter or RRV which followed national guidance. Aircraft operators received live real time notifications which were also sent through to the pilot and any hazards were uploaded onto the map held on the computer device inside the aircraft. This meant staff could be kept updated of changing risks to the helicopter in relation to travelling by air.

Staff carried out an emergency scenario of the day as part of the crew briefing from the emergency flight manual. A red or amber alert from the manual was selected and crews worked through the emergency checklist for aviation. An example of this was a generator failure or bird strike incident. Crew members flew with visors to protect their faces in such instances.

A pilot load sheet was completed each shift to determine the how much could be loaded onto the aircraft and where it should be loaded, the level of fuel and medical equipment which could be carried and for how long. Limits to flying levels of range of visibility were in place to ensure the safe usage of the aircraft. In the event of weather conditions preventing flight, a standard operating procedure was in use, setting out the use of the rapid response vehicle, meaning the service could respond in as timely and efficient way as possible.

The service had enough suitable equipment to help them to safely care for patients. Both vehicles and helicopter were equipped with lifesaving and emergency equipment and processes were in place to ensure vehicles and helicopter

could be replaced on the same day in the event of a breakdown. The air base held a stock of consumables, all of which were sealed and in date. A consumable store at the aircraft base was re-stocked on a weekly basis. All consumable stock we checked was sterile, sealed and in date at the time of the inspection. An asset register set out the service and maintenance schedule of medical devices, such as the defibrillator and ventilators. These were all up to date.

Staff disposed of clinical waste safely which was collected from the service weekly.

Fire risk assessments, asbestos surveys and legionella checks were completed in line with national requirements. Managers were able to monitor this using an electronic activity tracker along with any associated actions.

Assessing and responding to patient risk

A proactive approach to anticipating and managing risks to people who use services is embedded and was recognised as the responsibility of all staff.

Staff used a nationally recognised tool, the National Early Warning Score (NEWS2), to identify deteriorating patients and escalated clinical concerns appropriately. Those patients airlifted from the scene were handed over to an emergency department team. As part of the handover, staff shared information about the patient's condition and deterioration, and risks observed. This took place also for any patients who were not airlifted and instead handed over at the scene to an NHS ambulance service for transport to an emergency department.

Staff knew about and dealt with any specific risk issues including major trauma to the elderly and children. For complex incidents staff were able to access clinical support 24 hours a day 7 days a week from a consultant on call. Equipment carried by the clinical teams was used to provide rapid testing and monitoring to enable care and treatment to be provided quickly and efficiently.

There was a proactive approach to anticipating and managing risks to people who use the service. Individual risk assessments were undertaken by staff of all patients including those with an additional need. This was to ensure the aircraft was the most suitable method of transport taking into consideration individual needs and preferences such anxiety, fear of confined spaces etc.

The service used standard operating procedures based on national guidance and clinical research to support clinicians to respond to deteriorating patients or those requiring emergency treatment. These included conditions associated with suspected or identified stroke, cardiac arrest, haemorrhage, and a crisis with a pregnancy. A standard operating procedure set out the skill mix requirements for dual working to allow full critical care interventions. The service was clear this was not a role to be undertaken by a lone individual, but by a team of a Pre-Hospital Emergency Doctor (PHEM) and Critical Care Paramedic (CCP). This related to human factors in extremely tense and stressful situations. To support crews with this, the service had considered the lay out of the emergency response bags meaning that the clinician first at the patient carried the primary bag with immediate interventions such as basic airway adjuncts, oxygen, major haemorrhage kit, whilst the member following carried the secondary bag which contained the more specialised airway equipment.

The condition of the patient was described and reported to the air ambulance service by the NHS ambulance trust that took the initial call from the patient or caller. The helicopter crew received regular updates about the patient's condition while on route so they could be prepared to provide the most appropriate care.

Shift changes and handovers included all necessary key information to keep patients safe. Daily crew briefing sessions were held at the beginning of each shift and included detailed information relating to hazards, weather, planned events and incidents, as well as mechanical issues and hospital challenges.

A patient documentation audit between June 2022 and May 2023 found that 100% of the 137 cases reviewed met the key performance indicator which included recorded clinical observations.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service was almost fully staffed with 1 full-time vacancy for a critical care paramedic, which was advertised. The service's senior team were responsible for providing enough staff with the right skills and expertise to operate safely. The service had enough doctors trained in pre-hospital emergency medicine, critical care and anaesthesia to crew the helicopter at all call outs'. Doctors were employed on a range of different working-time contracts with some extending their individual training and skills by working on secondment with The Air Ambulance Service.

The service also employed staff in support roles, although the majority were trained critical care paramedics who maintained their skills by being on the rota. None of the staff we spoke with had concerns about safety or fatigue caused by working long or extra hours and said rotas were managed well to ensure any regulations about flying time were closely observed and met.

Managers reviewed professional registration, Disclosure and Barring Service checks and practicing privilege agreements every 2 years, in line with the standard operating procedure set out by the service. All checks had been undertaken and were within date.

Turnover rates for the service were low. Managers told us they were below 1%.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed the notes of 6 patients which were in line with the medical records operating procedure, setting out the level of detail expected within the patient record form. This included mode of transport, cannulation information, cardiac monitoring, sedation assessment and primary and secondary surveys.

Managers audited records regularly as part of the services governance system audit. The audits showed compliance against recognised standards.

Staff completed handover records which were detailed and provided information to other services about the patients' condition, treatment and medicines prescribed. This enabled patients to transition seamlessly between services.

Records were stored securely in an encrypted electronic system, which was password protected.

Outstanding ☆

Patient transport services

Medicines

Staff met good practice standards in relation to national guidance and contributed to research and development of national guidance. Compliance with medicines policy and procedure was routinely monitored and action plans were always implemented promptly.

Critical Care Paramedics (CCPs) operated under patient group directions (a legal framework which allows some healthcare professionals to supply and administer medications to a specific group of patients without the need to prescribe) to administer certain critical care medicines when required. Otherwise, CCPs delivered medicines in line with paramedic JRCALC guidelines within their normal scope of practice. These were in date and available to all staff.

Staff completed medicines records accurately and kept them up-to-date. Managers and staff audited medicines weekly and completed twice daily checks of fridges containing medicines.

Manager used the results from the audits to generate actions for improvement and themes in medicine errors. Managers shared the audit outcomes, so staff learned from incidents to improve practice. In response to the findings from the weekly audit the layout of the clinical response bags was altered, which meant medicine (boxes and ampoules) were no longer being damaged in transit. Audit results from April, May and June 2023 were 100% compliant and demonstrated the medicines were stocked in line with the checklist. Medicine usage was traceable to the patients and controlled medicine checks were completed in line with the medicines management policy. Staff stored and managed all medicines and prescribing documents safely. Medicines were stored at the location in a locked room with access restricted to clinical staff. Checks were undertaken twice daily to ensure they were stored at the correct temperatures.

Staff followed national practice to check patients had the correct medicines when they were seen and treated. Patient records identified medication administered and this information was also shared verbally when patients were handed over to other services. An annual medicine review was undertaken by operational and clinical management team and service level agreements were arranged with the pharmacy stockists. Between May 2022 and May 2023, 3 incidents relating to medicines had been reported. One related to a broken ampoule, 1 an incorrect tally of stock and the third a human error in administration. Staff learned from safety alerts and incidents to improve practice. An electronic records system recorded any safety alerts and incidences which were discussed with staff. The service worked closely with stakeholders to share learning from incidences.

The service had a system for the safe destruction of controlled medicines which was in line with Home Office requirements. An annual medicine review was undertaken by the pharmacy lead for the service and service level agreements were arranged with the pharmacy stockists.

Incidents

There is a genuinely open culture in which all safety concerns raised by staff and people who use service were highly valued as being integral to learning and improvement. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the service's policy.

Outstanding ☆

Patient transport services

Staff reported incidents in a timely way. The information from the service showed incidents, serious or otherwise, were rare events. However, all incidents were investigated for any learning or changes to practice. The service had a learning culture and any learning, however large or small from an incident, was used to change or improve practice where possible.

Staff understood the legal requirements of the 'duty of candour'. The duty of candour requires services to be open and transparent, and to give patients and families a full explanation and apologise if and when things go wrong. Staff were open and transparent and gave patients and families a full explanation if or anything went wrong. A duty of candour standard operating procedure was available to staff. Mandatory prompts were installed on the electronic incident reporting software and duty of candour was discussed monthly at the operational team meeting.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care through regular team, governance and committee meetings. Although the service rarely experienced serious incidents, staff told us they would be debriefed and supported after any serious incident. This extended to staff being involved in episodes of emergency care which were upsetting or stressful or caused anxiety.

Is the service effective?

Good

The service had not been rated before. We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Any proposed change to clinical practices were reviewed initially by 2 doctors to ensure it met current best practice. The person completing the proposal included a rationale for the change frequency of use and estimation of cost. This was reviewed at the monthly clinical review group before being escalated to the clinical governance group for sign off.

At handovers of patients to NHS staff (NHS ambulance crew or emergency department staff), the air ambulance staff referred to any recognised psychological and emotional needs of patients, their relatives and carers where this was required.

Each patient record and episode of care (the service referred to these as 'incidents') were reviewed by a clinician to review practice and the outcome for the patient. Part of the review was to ensure national guidance and evidence-based practice was followed and adhered to.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. We reviewed 6 patients' record. The service had a range of pain medicines to provide clinicians with a range of options depending on the critical nature of the patient. This included medicines suitable or adjusted for use for children and adults of different weights and sizes. Audit records showed patients received pain relief soon after it was identified they needed it, or they requested it. Staff prescribed, administered, and recorded pain relief accurately. Various pain relief tools were used depending on the scenario including pictures of faces and a 0 to 10 score.

Any pain medicine administration records or pain management decisions taken were handed over to receiving staff in the NHS ambulance service or emergency department.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. Care and treatment of all patients was closely monitored and any findings which suggested improvements could be made were reviewed and acted upon where appropriate.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This included clinical audits, such as for cardiac arrest including return to spontaneous circulation, use of pre-hospital emergency anaesthesia, and response times from call to scene. The services audit of pre-hospital emergency anaesthesia (PHEA) and advanced airway management treatment in line with national guidelines was above the 90% target.

A review of patients who died or were seriously unwell (known as mortality and morbidity) were held each month and any learning from care and treatment was assessed under a standard set of criteria. The service also looked at those patients who were at high risk of death but went on to recover and reviewed what part of their care and treatment had contributed to a positive outcome. Findings, such as those, were used to change practice to improve and achieve good outcomes for patients.

Audit outcomes and patient reviews were discussed formally through the various staff meetings and governance committees, so they were shared with the widest possible audience. They were also discussed and reported to the NHS ambulance services through routine quality monitoring.

One patient told us, 'The Air Ambulance saved me and have given me a second chance at life.' A patient's relative told us, 'It has helped change all our lives.'

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had a highly skilled, trained and experienced workforce required to work in complex cases in terms of clinical need and the

environment around the patient. Staff were encouraged and enabled to gain new skills, regularly refresh their skills, and undertake further academic university qualifications to enhance their roles. We were told by staff they were given the time and funding to work on education and training. The service had arranged for some training to be undertaken in NHS hospitals, such as laryngoscope training which was provided under NHS operating-theatre conditions.

Critical care paramedics were highly trained in additional skills enabling them, alongside the doctors, to treat patients who required invasive surgical procedures at the scene, managing major and multiple trauma incidents, and giving sedation where required. Critical care paramedics undertook a technical training programme provided by the aircraft operator. This was part of the programme to progress to full HEMS (helicopter emergency medicine service) status and qualify as a Technical Crew Member. Staff were only permitted to carry out surgical procedures to which they had been fully trained and declared competent. When HEMS paramedics were signed off as competent, they were enrolled onto a master's education programme in critical care medicine. All paramedics were provided with a five-yearly refresher course in driving skills under blue lights.

Managers gave all new staff a full induction tailored to their role before they started work. This involved working closely with experienced staff, being mentored, and shadowing episodes of care until they were approved and authorised as competent to work unsupervised.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had formal annual personal development reviews and a series of more regular and less formal conversations with their managers. Observed practice shifts were also arranged as part of the performance review assessment as well as a look-back at difficult and challenging cases. The completion rate for annual performance reviews was at 100%. Staff were given the opportunity to obtain further training and qualifications.

There were regular team meetings for sharing information and updating staff. These meetings were also to enable staff to give feedback where other learning might be recognised. Critical care paramedics met together every two months, and this was using an online meeting option so as many could attend as possible. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers also identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings among the clinical staff to discuss patients, equipment and facilities and improve care and treatment. Staff worked with a range of multidisciplinary staff, primarily those in the NHS with whom they handed over the patient for ongoing treatment.

The service also worked with other emergency services, such as fire and rescue service and the police force and were part of preparation and preparedness for planned and unplanned major events or incidents.

The service had service-level operating agreements with the local NHS ambulance trusts. There were regular performance meetings between the services, and quality and safety was the priority agenda item. The service worked closely with the NHS Ambulance tasking trusts and provided prompt updates surrounding service provision or changes to normal terms. Representatives of the 2 ambulance trusts the service provided positive feedback and described an effective working relationship.

Outstanding ☆

Patient transport services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interests, taking into account what they could ascertain from others about the patients' wishes, culture and traditions. If a patient was unconscious, unable or unfit to provide consent at the time due to their injuries, the service followed national guidance in order to explain to the patient what decisions had been made should the patient regain consciousness in their care. Otherwise, staff made sure patients consented to treatment based on all the information available.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff clearly recorded consent or best interest decisions in the patients' records. Relatives said they were consulted and involved in making the best decisions when patients were unable to express their preferences or give consent. The parents of 2 children said they were approached to give consent in line with their parental responsibility.

Is the service caring?

Outstanding ☆

The service had not been rated before. We rated it as outstanding.

Compassionate care

People were truly respected and valued as individuals and were empowered as partners in their care both practically and emotionally at the time of the incident and in its aftermath.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. This included protecting patients from the weather, talking to them, and holding their hands when heavy and noisy machinery was operating in the background at road traffic collisions. Staff told us they used blankets and screens when possible to make sure patients were appropriately covered and to protect their dignity.

All the patients and relatives we spoke with were consistently positive in their praise about the way staff treated them. All felt the service had provided exceptional care and treatment. A patient's relative told us staff, 'explained everything to me,' and constantly gave instructions on how to support the patient and keep them calm. Another relative told us, 'They really know their job, they were unbelievable.'

Patients said staff treated them well and with kindness. All the people we spoke with said the staff were kind and compassionate. One person told us the service supported the transfer of a deceased patient from their home to reduce the distress to other family members living there. They said this had a positive impact on reducing their grief and

assisting with them to come to terms with their loss. As a result, the family have offered their support to other grieving families who have used the service. The service recognised it could be upsetting when patients meet staff who had supported them during a traumatic time and so were in the process of organising a dedicated visitor room at their base so people could meet staff and reflect on their experience in private.

Staff followed policy to keep patient care and treatment confidential by sharing patient details at the hospital handover only and keeping patient report forms safely stored where they were not accessible to others. Data sharing agreements were in use, place to support the confidentiality of such care and treatment.

Emotional support

Staff supported people to express their views and empowered them to navigate their journey of recovery.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were fully committed to working in partnership with patients and relatives and understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Patients and relatives we spoke with said that staff gave them and those close to them help, emotional support and advice when they needed it. This included after the incident when a Clinical Liaison Officer invited patients and relatives to the service, giving them the opportunity to meet the crews and ask any questions they had thought about after the incident. One person told us, 'We were afforded the time to be able to process and ask for support at our own pace, it's so, so beneficial to be told we can contact them at any time to get answers.'

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff recognised the importance of advocacy and support required for patients and relatives following serious incidents. There was a dedicated patient liaison officer who was responsible for supporting people and their families who had used the service. They could signpost people to additional care, such as psychological services and support groups. An electronic trauma application was shared with patients and their relatives, which enabled them to keep a contemporaneous journal of both good and bad days they may experience. The service had recognised this enabled reflection and empowered patients and relatives to become active members in their journey of recovery.

The relative of one patient told us, '(We have had a) detailed minute by minute recount of what happened… this been useful in order to inform us as a family what happened and allow us to process it.' Another person told us the service spoke with a hospital to supply them with an update on their loved one's condition and to provide reassurance.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition, express their views and be actively involved in making decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with the relative of one patient told us they were kept up to date with the treatment being provided which enabled them to make decisions in the best interest of their partner. A Clinical Liaison Officer (CLO) spoke with patients to identify if there were any aftercare requirements for them or their families. The CLO was able to signpost people to the appropriate care and support agencies. Staff had created an innovative closed social media peer support group to enable them to manage their own health and care when they could and to maintain independence as much as possible. The group was

monitored by the social media manager for the service and included safeguarding consideration and group rules. This group was not open to the public. Patients or their loved ones wanting to join provided time, date, and location of incident so the service could ensure those requesting to join were genuine. The purpose of this group was to help patients and relatives in finding support from one another.

Patients and their families were invited to the base to meet the staff who had provided their care. This gave people the opportunity to ask questions, express their thanks and gain an understanding of the events leading to them needing care. People told us they found these visits cathartic and many made return visits to the base. One person told us that because of their experience they were supporting the service's campaign to increase the number of defibrillators in public places.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. People were given the opportunity to provide feedback when the service handed patients over to other services and there was a process in place for people to attend the service when they were able. We saw the service had arranged open days and opportunities for people to meet the staff who had delivered their care. People told us they found these visits cathartic and enhanced their wellbeing and recovery. We saw thank you cards and compliments displayed in the service's base.

Patients and their families could give feedback on the service and their treatment. Staff supported them to do this in a variety of ways so nobody such as those not able to use technology were excluded. Quick response (QR) codes, business cards and written forms were used. Over the last 12 months there were 8 comments submitted using the QR codes. Feedback for the service was overwhelmingly positive. All respondents felt their wishes and privacy were respected and were treated with dignity and respect. Feedback included, 'Truly remarkable humans who cannot understand the enormity of the impact they have on their patients and myself as a parent. Professional, reassuring yet realistic. Compassionate, diligent, and caring', 'The surgeon who rebuilt me said that the swift response and treatment at the scene…saved my hip and enabled me to walk again' and 'Super pleased that our boys last journey was with you guys and that we are part of your family – thank you for listening and being there'.

Is the service responsive?

Good

The service had not been rated before. We rated it as good.

Service delivery to meet the needs of local people.

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

The service was planned and organised so it met the needs of the local population. Managers had the knowledge and experience to determine where the areas of highest need were likely to come from and plan services accordingly. This included places with higher levels of risks and the trends and changes in conditions affecting patients such as an increase in knife crime.

Staff were aware the office and staff facilities on the airfield needed updating and had outgrown their purpose as the business had developed and expanded. There were plans drawn up for new premises, but this had been complicated by

changing demands from the airfield landlords. The service was making the best use of the premises with a range of private staff offices and a large training room. It was taking delivery of air conditioning equipment on the day of our inspection, as staff had reported the premises were often warm in the summer months, particularly for staff required to wear safety equipment at all times in a state of preparedness.

The service had identified landing sites for all the partner NHS hospitals it served in the localities and surrounding areas. These were regularly reviewed for safety. Other sites where patients were located were reviewed in flight by the aircraft crew to ensure they were as close as possible, but as safe as possible for the staff and the public. The aircraft crew took the decision when it was determined not safe to fly and/or not safe to land. The pilots took the decision when it was determined not safe to fly and/or not safe to land.

The service had regular meetings with stakeholders to identify trends in patient care, so they were prepared to meet the changing needs of patients. They had worked with other agencies to develop care pathways in response to an increase in stabbings and shootings.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary adjustments to care and treatment to meet all their needs. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Due to the nature of the service, and patients needing help in emergency and highly unplanned circumstances, there were limited options to provide support for people with communication difficulties, including language barriers. Staff would use family or friends to help with any interpretation and had access to a language line when it was possible to use safely and effectively.

Telephone translation services could be accessed by crews 24 hours a day 7 days a week, so patients, loved ones and carers could get help from interpreters when needed. At the time of the inspection the service was in the process of obtaining multilingual phrase books and picture cards. Patients who used British Sign Language as a first language had access to face-to-face smart phone applications if required.

People who had used the service had access to an accessibility button which allowed them to increase the size and font of text on the service website. This helped people with a range of differing needs to access information. This was in line with the Accessible Information Standard. In addition, details around information and communication needs could be recorded on the electronic patient report form and highlighted to staff at the acute NHS trust on handover.

The Clinical Liaison Officer had photographs of equipment, such as a LUCAS (Lund University Cardiopulmonary Assist System) device which provides mechanical chest compressions to patients in cardiac arrest. This was to support patients understand the type of care they had received following recovery.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Outstanding ☆

Patient transport services

The service operated the helicopter only when flying conditions were within legal parameters. This predominantly was during daylight hours and in safe weather conditions. If the helicopter was grounded, or subject to routine or unplanned maintenance or repair, the service had a lease agreement to obtain a spare helicopter the same day. A Rapid Response Vehicle (RRV) could also be used to travel to the patient. The helicopter and RRV were fitted with the same level of equipment so either transport could be used. The RRV was available throughout the nighttime hours and when the helicopter was offline. Decisions were also made when the RRV was the better option for the circumstances, as there was a major road network around the airbase in the Coventry area.

As the helicopter and RRV service was highly specialised and limited in terms of capacity, there were generally minimal delays in handover times at NHS emergency departments or for NHS ambulance transfers, to release this valued and limited resource back into service. Aircraft were the fastest civilian twin engine aircraft in their class capable of 185mph and achieved an average response time of approximately 13 minutes.

While on route to calls, crews received regular updates about a patient's condition from ambulance providers. This enabled the service to agree if it was best suited to meet the patient's changing needs or could be diverted to other calls or stood down and made available for further calls.

The service monitored response times and discussed these with the tasking NHS ambulance service at regular quality meetings. The service performed well when compared to services in other counties. The service also reviewed the care and treatment it was able to provide to ensure if gave the best and optimal service to the patients it served.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. Staff said the service would treat concerns and complaints seriously, investigate them and share lessons learned with all staff, including those in partner organisations. However, the service had to date never had a complaint and concerns were minor.

The service provided information on its website about making a complaint, raising a concern or generally getting in touch with the service. Staff understood the policy on complaints and knew how to handle them, although the service had received a minimal number of formal complaints in the last 20 years. The service actively sought the views of people who had used the service and supported them to visit the service and provide feedback in person. Managers had a proforma which would be used to investigate complaints if received. This set out mandatory actions including an acknowledgement letter, contact with complainant and verbal feedback of the outcome for both the person raising the concern and staff members. Learning from complaints would feature as part of the whole staff team meetings managers told us.

Staff understood the policy on complaints and knew how to handle them if received.

Is the service well-led?

Outstanding ☆

The service had not been rated before. We rated it as outstanding.

Leadership

Patient transport services

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

Staff told us leaders were visible and approachable within the service. Staff understood leaders' roles and their responsibilities. The leaders' profiles were promoted through a formal structure of regular meetings and briefing documents. Staff were supported to develop their skills and progress in their careers. There was an embedded system of leadership development, which included recognising aspiring leaders and a leadership framework to support succession planning. Staff told us they were supported with protected time and opportunities to develop their skills and knowledge.

Leaders had the skills, knowledge, experience and integrity to run the service. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Operational staff felt leaders within the service had high levels of experience, capacity and capability to support them in their roles.

Leaders had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was a leadership strategy and development programme, which included succession planning. We heard about the leadership strategies used to ensure and sustain delivery of care. These had led to the creation of data sharing agreements and key organisational priorities for the service.

Leaders had a deep understanding of the challenges to quality and sustainability as well as risks to performance. Leaders had action plans to address challenges identified. The most recent example came from the COVID-19 pandemic where filtering face piece 2 (FFP2) masks staff wore when caring for patients were difficult to get. This presented a risk of not having enough for staff to be able to care for patients. The service took action to procure as many masks as possible, collected them and after this, distributed them not only within their own service but also other organisations, such as local NHS trusts and ambulances services to support the wider COVID-19 response.

Vision and Strategy

The service had a clear vision and credible priorities to deliver high-quality sustainable care to people and robust plans to deliver them.

The service had a clear vision and a set of values both of which had quality and sustainability as top priorities which were aligned to the wider health economy. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. Staff knew and understood what the vision, values and strategy were, and their role in achieving them. There were 5 strategic ambitions and below these were tactical objectives to support delivery of the strategic aims. For example, one of the tactical objectives had been to review all the ventilators and provide the most up to date and appropriate equipment.

These were realistic, aligned to local plans in the wider health and social care economy and aimed at delivering quality care. For example, improving digital infrastructure (the services ability to connect widely both virtually and physically), review of estate footprint (size and location) and progression with public and preventative health initiatives such as attempting to reduce knife crime.

Staff had a clear understanding of the strategic directions of the service and contributed to the setting of the strategy, aims and objectives. Annually all staff attended a conference where they contributed ideas and feedback. Senior leaders used the feedback at executive level strategic meetings. In addition, feedback from system governance meetings was used to inform the setting of the service strategies. This provided a structured planning process in collaboration with staff and stakeholders to meet the needs of the relevant population.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt supported, respected, valued and were positive and proud to work in the organisation. The culture was centred on the needs and experience of the patients served in the community. Action taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Staff felt they were treated equitably. Clinical advice or supervision was available to staff 24 hours a day, every day. Staff and managers gave examples of opportunities to reflect upon their clinical practice to develop professional and personal skills. These included sharing of good practice and lessons learnt across a wider system and developing in line with the most recent clinical developments and research. The service was centred upon the needs of the people using and the staff working within the service.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively. Staff could access confidential support if they needed it. Managers worked hard to recognise and address stress and pressure upon their staff given the high level of patient acuity in terms of trauma, injury and illness with which staff were exposed to daily. There was an external employee assistance programme provided and access to occupational health as standard. Staff were given access to psychological or counselling support if needed and trauma risk management (TriM) support. There was also access to physical therapy sessions. Any accidents or injuries at work were managed through a policy and standard operating procedure.

Leaders promoted a culture where staff could feel safe and focus on their wellbeing. A lone worker policy was available, as were risk assessments around the safety and welfare of staff. Leaders ensured mandatory safety checks and briefings. Staff were confident to speak up in the event of missing or defective kit, equipment or anything which may be of concern.

The service had a reflective culture and strong collaboration, team working, and support was evident across all functions of the service. Staff and managers gave examples of opportunities to reflect upon their clinical practice to develop professional and personal skills. These included sharing of good practice and lessons learnt across a wider system and developing in line with the most recent clinical developments and research. The service was clearly centred upon the needs of the people using and the staff working within the service.

Incident reporting feedback had been strengthened within the service. The manager told us personal feedback was provided for each incident and near miss reported, including what was reported and what actions had been taken. As a result, the service had seen an increase in its reporting culture.

Governance

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

There were effective governance structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. The board and other levels of governance within the service interacted with each other appropriately. Various meetings including operational, clinical governance and immediate care governance groups, as well as mortality and morbidity, and audit and risk compliance management groups were held monthly. Meetings included reviewing all the key performance indicators, which were based on NHS Ambulance Framework and industry best practice. Groups looked at themes and trends to review for learning opportunities and any areas relating to duty of candour or safeguarding.

Standing agenda items were set up for each meeting. The operations meeting included quality matters such as infection, prevention and control; risk register; budget; operational cover; aviation time; incidents; compliments and complaints, training and education. An action tracker monitored all actions and clearly indicated progress with the action. Terms of reference for each group set out its purpose, objections, membership, administration arrangements, key documentation and standing agenda items. Key decisions from the last meeting were reviewed along with actions at the beginning.

Corporate governance meetings were held monthly within the operational team.

There were regular meetings with the tasking NHS ambulance service with a set agenda looking at all aspects of performance and governance. We spoke with senior representatives from both NHS ambulance services, and they were very complementary about the leadership. They gave examples of good joint working to review and improve the care people received from all stakeholders.

There were a range of clinical audits to determine if care and treatment was delivered safely and met performance requirements. This included areas such as patient records, anaesthesia provision, use of sedation and pre-hospital care. Any shortcomings or areas for improvement were discussed through the clinical governance group.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, patient-centred care.

Staff recruitment followed policy and legal obligations. Vacancies were reviewed and the job description approved by a clinical committee before being advertised. The organisation employed a human resources specialist to undertake the recruitment process at the headquarters. Staff shortlisted were invited to interview where a minimum of 2 staff were present, and notes were made and stored. All the safety checks including review of two current references, professional registrations and qualifications were undertaken before the person commenced the role. Each new member of staff was subject to a competency sign off period surrounding aviation and clinical areas. In addition to this, new staff were subject to a 6-month probationary period.

Governance arrangements were proactively reviewed to reflect best practice and a systematic approach was taken to working with other organisations to improve care outcomes. Service level agreements between third parties including blood products and surgical equipment were set up. A monthly flight report was produced which reviewed monthly return of aircraft flying hours, aircraft utilisation, contract compliance, base audits, and safety report along with maintenance forecast summary. This was shared with the aircraft provider at monthly air provider meetings.

The service had a process to ensure staff did not work excessive hours. All contracts included working time directive details and set out how staff must not attend work at the service straight from another employer or shift. Pilot hours were considered as part of shift planning and consideration was given to the length and patterns of shifts.

Data sharing agreements were in place between NHS providers and the service to allow the transfer of information on patient outcomes to be shared.

Management of risk, issues and performance

The service was committed to risk management and openly addressing problems identified. Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements monitored.

Leaders used an incident reporting system and risk register for the identification, recording and management of risks. This included data on risk mitigations, action plans, probability and impact. The service reviewed its risks frequently as a key part of the governance system. There was alignment between recorded risks and what staff said was 'on their worry list'. Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Leaders could identify the top 3 risks and information relating to these was displayed in the staff areas so staff could understand the key challenges the service faced. Leaders followed a risk management policy which set out the operating procedures including escalating key risks to the executive leadership team for board review and approval of any mitigating actions.

Potential risks were planned for. Emergency action plans were in place for the event of an air incident and a separate business continuity plan set out key actions and contacts for the event of an incident threatening critical business function. Leaders had a rota to cover 24/7 on call in case of emergency incidents. This was in addition to 24/7 clinical support. Leaders were involved in multiagency incident rehearsals to develop learning to improve responses to major incidents.

Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Leaders reviewed incident themes at operational and clinical governance meetings. This included near miss incidents meaning the service could take preventative action to reduce risk. There was a programme of clinical and internal audits

to monitor quality, operational and financial processes. This included the audit, risk and compliance group and monthly operations meeting along with a clinical supervisors group meeting which reviewed all clinical support calls including the advice given, actions taken and outcome of each call. Budget sheets were sent out monthly. The Director of Operations completed IP&C assurance checks to confirm the information being presented was factual.

Leaders were involved in multiagency incident rehearsals to develop learning to improve responses to major incidents. For example, one incident rehearsal was based on a bombing which took place at an events arena in a major city. All staff were expected to take part. All staff had undertaken training on the Joint Emergency Service Interoperability Programme (programme of services working together).

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information was used to measure improvement, not just assurance. Staff had sufficient access to information and challenged it when necessary. There were clear service key performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. The information used to report, performance manage and delivering quality care was accurate, valid, reliable, timely and relevant. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

Staff could find information and data they need which included all clinical statement of purposes listed on the public website and handheld electronic tablets used whilst on the helicopters.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. All systems were password and fire wall protected and the service had the same security standards as NHS providers in terms of encryption and NHS email addresses. As a result, information could be shared securely and confidentially. Data sharing agreements has been created with most NHS providers to allow patient outcome monitoring and learning from incidents.

All systems were password and fire wall protected and the service had the same security standards as NHS providers in terms of encryption and NHS email addresses. As a result of this, information could be shared securely and confidentially. Data sharing agreements has been created with most NHS providers to allow patient outcome monitoring and learning from incidents.

The nominated individual submitted notification both statutory and otherwise to the relevant external organisations as required. The service had a Caldicott guardian, and all staff undertook training on data protection.

As part of the service strategic aim of improving data access, CCTV monitoring to the medicine storages areas was recorded to a cloud-based system. This enabled traceable and auditable information such as key fob access to be monitored.

Outstanding ☆

Patient transport services

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the services and culture. There was a well-supported and continuously developing patient liaison service including the use of QR codes to enable people who used the service or the families and friends to give constructive feedback.

The crews carried contact cards to give the details of the Clinical Liaison Officer should anyone want to contact them. At the current time the service generally had contact with people who came to them, but there was a proposal under way to determine if the service would contact people more directly in future to engage and support them.

Staff were actively engaged so their views were reflected in the planning and delivery of services and in shaping the culture. Personal feedback to staff following incident reporting had meant the staff felt more engaged and valued. An increase in the incident reporting culture had also been noted. An annual staff survey as well as a bi-annual pulse survey were used within the service to sense check satisfaction.

There was a sensitive approach to any patient contact, and certain situations were avoided if there were safeguarding concerns or involved criminal investigations. Otherwise, the Clinical Liaison Officer sent a card to bereaved people and had a range of contact information they could provide for additional professional support. Feedback from patients was used in the clinical governance meetings and directly to the crews to provide, almost always, positive collaboration around the quality of the patient care provided. There were plans to develop engagement initiatives in future to link with the NHS ambulance services in work with schools and students in order to support their future strategic objectives.

A number of families and patients had visited the airbase to meet crews and talk about their experiences. This was welcomed by staff and patients. An annual family fun day had been introduced and an annual fitness fundraiser for all staff provided the opportunity to engage and have fun together. Webinars, group discussions and conferences with child bereavement charities and road collision charities had also been undertaken by the service previously.

In other engagement activities, the service took part in open days, had a range of publicity materials, and extensive information about the service and its history on its website. There were plans to develop engagement initiatives in future to link with the NHS ambulance services in work with schools and students.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the urgent and emergency care system and the needs of the relevant population, and to deliver services to meet those needs. Staff from the service worked with police and fire brigade colleagues to attend schools and educate the public about the risks of knife crime and speeding causing road traffic collisions. At the time of the inspection the service was in the process of trying to obtain invites to the integrated care board regional meetings given that the service accounted for a large proportion of the major trauma brought into the regional NHS trusts.

Regional trauma networks both strategically and clinically were represented by the service as well as board level representation at both local NHS ambulance trusts. The service attended the enhanced critical care group which fed into the clinical steering groups. Information sharing, such as standard operating procedures, could be standardised through group discussion. In addition, the service attended the intermediate care governance group.

Outstanding ☆

Patient transport services

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. There was a robust system for learning, continuous improvement and innovation.

Leaders and staff aspired to continuous learning, improvement and innovation. Staff had the opportunity to put forward suggestions for development to clinical practice. These included participation in appropriate research projects and recognised accreditation schemes. Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service. All staff could contribute to the quality improvement of the service, take ownership of developments, and were invested in the successful running of the service.

There was an embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Work was underway at the time of the inspection to provide community resuscitation and defibrillator training, as well providing the automated external defibrillators into the community. Work was being undertaken with an NHS ambulance service to map and understand where the greatest demand for the defibrillators should be placed.

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which lead to improvements and innovation. There were systems to support improvement and innovation work, and processes for evaluating and sharing the results of improvement work.

Responses to Coroners' requests for information ensured the service could feed back to its staff causation of death. This was thought to be an important aspect of reflection and learning within the service, allowed the service to review its procedures and supported greater understanding of mechanisms of injury as well as underlying pathology.

The provider had a business plan to relocate the service to larger premises to best meet the changing the needs and demographics of people who use the service. The proposal included a rationale, and estimations of cost.

Work had begun around public and preventative health; the knife crime initiative was underway and staff members had been encouraged to raise similar initiatives.