8. Conclusions

"Reforming Emergency Care"[40], outlines the NHS strategy for improving and developing emergency care. The strategy is based on six leading principles;

- Services should be designed from the patients' point of view
- Patients should receive a consistent response, wherever, whenever and however they contact the service
- Patients' needs should be met by the professional best able to deliver the service
- Information obtained at each stage of the patients' journey should be shared with other professionals involved in their care
- Assessment or treatment should not be delayed through absence of diagnostic or specialist advice
- Emergency care should be delivered to clear and measurable standards.

These principles were directed to hospital emergency care and out of hours primary care. However all of these principles are equally relevant to pre-hospital care. We should therefore: "continue to improve the speed and quality of service provided to patients with emergency care needs".

The Air Ambulance Services have an important role to play in this, both by enabling patients to be reached more quickly than by a ground ambulance and by providing an extra tier of specialists for complex patients in difficult situations. This extra tier of specialist care would provide smoother transition through the care pathways and extend emergency care networks as dictated by current Department of Health initiatives.

This Framework aims to provide a structure through which Air Ambulance Services and the NHS Ambulance Services with whom they work can deliver a high and consistent standard of operational management and clinical care. A list of suggested best practice is given below.

1. Governance

1.1 Trustees and managers should be familiar with the report 'Taking Healthcare to the Patient: Transforming NHS Ambulance Services', in particular those recommendations that can be applied to HEMS operations.[40]

1.2 Consideration should be given to any trustees who serve on the charity boards that have a direct and corresponding relationship with partner organizations such as co-located Ambulance Service Trust. Where there is a trustee with a potential conflict of interest, the charity should clearly state the way in which any potential conflicts will be declared and dealt with.

1.3 All air ambulance charities should ensure that their constitutional documents have clear objects and powers of delegation and have Memorandums of Understanding and Service Level Agreements in place.

1.4 Appropriate governance arrangements should be in place including, where appropriate, a medical director and operations manager to oversee clinical standards and operational performance.

1.5 Charities should review and demonstrate the impact they wish to have on the people who benefit.

1.6 Charities should be able to demonstrate their independence in carrying out their charitable purpose and not for the purpose of implementing the policies or directions of any third party.

1.7 Grant applications should be made within a national standard format to be agreed by the charities. Ambulance Services should neither invoice nor recharge costs as an alternative to grant application.

1.8 Trustees should ensure that they have approved delegated authority to third parties.

1.9 Each Ambulance Service should nominate a liaison officer of at least divisional commander rank to act as a direct, one point of contact link between charity and Ambulance Service to ensure regular and effective communication.

1.10 Procurement of aircraft and/or accompanying services from aircraft operators should be conducted within the charity's best working practices.

1.11 A self audit and peer review process should be developed to enable services to assess themselves against the Framework and identify areas for improvement and development. This process should be developed under the aegis of the Association of Air Ambulances.

1.12 In order to support the identification and development of good practice, comparative performance measures should be developed.

2. Clinical Standards and Clinical Governance

2.1 A National Clinical Advisory Group should be instituted to which all members report (UK National Clinical Advisory Group) and which has a membership representing all the constituent Air Ambulances Services.

2.2 Each Air Ambulance Service should either develop a Clinical Advisory Group or share existing clinical advisory arrangements with an NHS Ambulance Service.

2.3 Clinical quality measures and clinical audit should be embedded within all HEMS organisations and a single repository and data set established. A system of clinical and outcome indicators should be agreed.

2.5 Each service should ensure that they have clinical governance arrangements in place including a robust clinical occurrence / incident reporting system, a system for recording and responding to enquiries and complaints, and a comprehensive electronic data base to complement the paper-based medical records / run sheets.

2.6 Each Air Ambulance Service should work to a core set of nationally agreed operational procedures covering both clinical and non-clinical procedures.

3. Operational Management and Dispatch

3.1 Trustees' discretions should be formally delegated to a senior ambulance service employee responsible for call selection and dispatch.

3.2 There should be a standard competency framework and core training for staff involved in call handling particularly where HEMS should be used.

3.3 Tasking arrangements should ensure optimum dispatch and use of helicopters. Dispatch criteria / protocols should be established to ensure a consistent standard of tasking.

3.4 There should be greater emphasis on developing local agreements for rapid referral of patients where there is evidence of improved outcomes.

3.5 For measuring HEMS response times, the clock should start when the call is connected to the ambulance control room.

3.6 There should be a multidisciplinary operational meeting at the start of each shift.

3.7 Charities and NHS Ambulance Services operating air ambulances should have standard operating procedures which are in line with best practice.

3.8 All HEMS / Air Ambulance Operations should have a Major Incident Plan, agreed with the NHS Ambulance Service.

3.9 Air Ambulance Services should agree 'mutual aid' agreement to augment their air resources at critical times.

3.10 95% of calls requesting air ambulance assistance should be answered in less than 5 seconds.

4. Staffing

4.1 HEMS doctors should be selected on criteria agreed by the organisation.

4.2 HEMS clinical training should be designed around the case mix they deal with.

4.3 There should be a rota of senior clinicians available for on-line medical advice. If the crew is a paramedic-only crew there may not be an automatic need for an on-call consult as clinical governance responsibility will fall under the clinical governance lead for the charity or the clinical lead for the charity.

4.4 Each service should have an annual training and continuing professional development plan.

5. Services in the Future

5.1 A separate review should be undertaken to establish the ability and willingness of charities in undertaking the additional work of night flying and inter-hospital transfers and the costs thoroughly investigated.