Magpas

Magpas Operational Base

Inspection report

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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?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

We have not previously rated this service. We rated it as outstanding because:

- The service provided mandatory training in key skills and worked with other partners and stakeholders to promote training compliance and opportunities for development.
- Staff understood how to protect patients, had training on how to recognise and report abuse, and they knew how to apply it. Staff and managers worked together with external stakeholders to safeguard patients.
- The service-controlled infection risk well and used equipment and control measures to protect patients, themselves and others from infection including the safe management of clinical waste. Staff were trained to use equipment and ensure that the services vehicles and premises were visibly clean using audit and maintenance schedules.
- The service used strong comprehensive safety systems, with a focus on openness, transparency and learning to protect people. Staff took a proactive approach to anticipating and managing risks to people and safety was recognised as being everyone's responsibility. Staff identified and quickly acted upon patients at risk of deterioration. External organisations were actively engaged in assessing and managing anticipated future risks and the service had comprehensive business continuity and emergency plans.
- 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 and gave staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and stored securely.
- The service used strong comprehensive systems and processes to safely prescribe, administer, record and store medicines. The service took a proactive approach to improving their medication safety.
- There was a truly holistic approach to assessing, planning and delivering care and treatment to people who used the service. There was a safe use of innovative and pioneering approaches to care in urgent and emergency care settings and staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- There was a genuinely open, and "Just" culture in which all safety concerns raised by staff and people who use the service were highly valued as integral to learning and improvement. All staff were open and transparent, fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of quality. There was ongoing, consistent progress towards safety goals reflected and learning was based on a thorough analysis and investigation of things that went wrong.
- All staff were actively engaged in activities to monitor and improve service quality and patient outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice and leaders used innovative approaches to implementing new roles and career development opportunities.
- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services. External stakeholders were consistently positive when describing multidisciplinary working and told us the service was focused on working together to save lives, limit the impact of life changing events and improve urgent and emergency care across the region.
- 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.
- People were truly respected and valued as individuals. Feedback from people who use the service and those who were close to them was continually positive about the way staff treat people. People thought that staff went the extra mile and the care they received exceeded their expectations. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.

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- The involvement of other organisations and the local community was integral to how services were planned and ensured services met the needs of local people and the communities served. People could access the service when they needed it and received the right care in a timely way and the service had developed innovative ways to improve access to the service.
- It was easy for people to give feedback and raise concerns about care received. There were active reviews of complaints and how they were managed and responded to, and the service improvements were made as a result across the service.
- Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Leaders had the skills and abilities to run the service, they understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a mission for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. These were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- There was a strong culture that was centred on the needs of patients. Leaders at all levels across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values to deliver high quality person-centred care. The service provided opportunities for career development and staff could raise concerns without fear. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and took actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected a wide range of 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.
- Leaders and staff used gathered feedback from people who used services and the public. This was then used to plan and manage services. They collaborated with local, national, international partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Leaders encouraged innovation and participation in research.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Outstanding ☆	We have not previously rated this service. We rated it as outstanding because: • The service provided mandatory training in key skills and worked with other partners and stakeholders to promote training compliance and opportunities for development. • Staff understood how to protect patients, had training on how to recognise and report abuse, and they knew how to apply it. Staff and managers worked together with external stakeholders to safeguard patients. • The service-controlled infection risk well and used equipment and control measures to protect patients, themselves and others from infection including the safe management of clinical waste. Staff were trained to use equipment and ensure that the services vehicles and premises were visibly clean using audit and maintenance schedules. • The service used strong comprehensive safety systems, with a focus on openness, transparency and learning to protect people. Staff took a proactive approach to anticipating and managing risks to people and safety was recognised as being everyone's responsibility. Staff identified and quickly acted upon patients at risk of deterioration. External organisations were actively engaged in assessing and managing anticipated future risks and the service had comprehensive business continuity and emergency plans. • 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 and gave staff a full induction. • Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and stored securely.

Summary of findings

- The service used strong comprehensive systems and processes to safely prescribe, administer, record and store medicines. The service took a proactive approach to improving their medication safety.
- There was a truly holistic approach to assessing, planning and delivering care and treatment to people who used the service. There was a safe use of innovative and pioneering approaches to care in urgent and emergency care settings and staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- There was a genuinely open, and "Just" culture in which all safety concerns raised by staff and people who use the service were highly valued as integral to learning and improvement. All staff were open and transparent, fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of quality. There was ongoing, consistent progress towards safety goals reflected and learning was based on a thorough analysis and investigation of things that went wrong.
- All staff were actively engaged in activities to monitor and improve service quality and patient outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice and leaders used innovative approaches to implementing new roles and career development opportunities.
- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services. External stakeholders were consistently positive when describing multidisciplinary working and told us the service was focused on working together to save lives, limit the impact of life changing events and improve urgent and emergency care across the region.

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- 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.
- People were truly respected and valued as individuals. Feedback from people who use the service and those who were close to them was continually positive about the way staff treat people. People thought that staff went the extra mile and the care they received exceeded their expectations. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- The involvement of other organisations and the local community was integral to how services were planned and ensured services met the needs of local people and the communities served. People could access the service when they needed it and received the right care in a timely way and the service had developed innovative ways to improve access to the service.
- It was easy for people to give feedback and raise concerns about care received. There were active reviews of complaints and how they were managed and responded to, and the service improvements were made as a result across the service.
- Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Leaders had the skills and abilities to run the service, they understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a mission for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. These were aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- There was a strong culture that was centred on the needs of patients. Leaders at all levels across the service promoted a positive culture that supported

Summary of findings

and valued staff, creating a sense of common purpose based on shared values to deliver high quality person-centred care. The service provided opportunities for career development and staff could raise concerns without fear. Staff were proud of the organisation as a place to work and spoke highly of the culture.

- 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and took actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected a wide range of 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.
- Leaders and staff used gathered feedback from people who used services and the public. This was then used to plan and manage services. They collaborated with local, national, international partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Leaders encouraged innovation and participation in research.

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Background to Magpas Operational Base

Magpas Operational Base is operated by Magpas and is a registered charity that provides a helicopter emergency medical service (HEMS) and rapid response service 365 days a year from an air base near Huntingdon. The service operates an air ambulance daily between the hours of 7am and 7pm and has 3 rapid response vehicles (RRV) that operate 24 hours a day. The service responds to demands from the local NHS ambulance trust emergency control room, where critical care paramedics triage emergency 999 calls and liaise with Magpas staff to deploy the most appropriate resource to emergencies.

The service covers the East of England and East Midlands regions and between 1 September 2021 and 31 August 2022, the service was activated 1,236 times, with 602 air ambulance activations and 634 RRV activations, and responded to 854 people, including 770 adults and 84 children.

At the time of our inspection, the leadership team shared their plans for the development of the service's new headquarters. Plans for the new headquarters were well in advance, underpinned by the service's strategic aims and objectives, and they planned to move to the new location in June 2023.

We inspected the service using our comprehensive inspection methodology, inspecting the domains of safe, effective, caring, responsive and well-led. We carried out our inspection on the 13 September 2022, at its location in Cambridge and we spoke with 12 staff, 4 trustees and 4 external stakeholders to gather their views on the service.

We last inspected the service on the 27 February 2018 and did not rate the service. At this inspection we have rated the service as good for safe, outstanding for effective, caring, responsive and well-led, and outstanding overall.

What people who use the service say

During our inspection we spoke with 7 patients and 1 relative, they told us about their experiences, and told us they had received outstanding care and treatment from the emergency and after care staff team. Many of the patients and relative who had used the service went on to become volunteers and to fund raise for the service, all of them told us they were proud to be part of the service and its mission to save lives.

How we carried out this inspection

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 many examples of outstanding practice:

- People benefited from the service's culture of learning, where leaders and staff responded openly when things went wrong and acted promptly to provide innovative care and treatment to save lives and limit the impact of life changing events.

Summary of this inspection

- The service's governance systems ensured incidents, safeguarding and complaints were comprehensively reviewed and feedback was used to improve the service and outcomes for people.
- The service conducted research on new methods of treatment and care, used new technology, new procedures and were continuing to challenge the limits and safe risks of what treatments were possible for patients.
- Staff were highly motivated to provide care and compassionate treatment in extraordinary circumstances. Patients we spoke with told us that the support and intervention of staff gave them outstanding care, life support and interventions which enabled them to go on and lead their lives to the full and limited the impact of their serious injuries or conditions.
- The service proactively engaged with a wide range of stakeholders and partners with the aim of improving its services and the quality of care for all people. This included working with; local NHS trusts training their staff, the police, fire service and other air ambulance services across the region and internationally to share learning and innovation.
- The service had a strong inspirational leadership team that consistently supported people across the service and created a positive patient focused culture. Learning, research and innovation was encouraged at all levels to improve patient outcomes, promote patient safety and achieve the services mission.

There were many more examples of outstanding practice not included in this summary. We did not include every example as the evidence included supported our rating of outstanding.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding

Emergency and urgent care

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

Are Emergency and urgent care safe?

Good

We have not previously rated this service. We rated it as good.

Mandatory training

The service provided mandatory training in key skills and worked with other partners and stakeholders to promote compliance and opportunities for development.

The service had systems in place to monitor staff compliance with mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training considered current best practice in relation to pre-hospital emergency medicine and ensured patients benefited from the range of life saving training and interventions provided by staff in an emergency.

Clinicians held employment contracts with their main NHS employer. At the time of our inspection leaders told us that clinicians were asked to confirm they were up to date with their NHS mandatory training. The service aimed to further improve training data collection to ensure that staff were fully compliant with all training. At the time of our inspection leaders told us they had a training system which ensured NHS staff who were unable to access training through their usual NHS employer would be able to access training offered by the service to cover any shortfalls. The service aligned training with the elements detailed in the *Skills for Health Core Skills Training Framework (2021) and* recognised training undertaken in NHS trust's that supported this framework.

The services annual 'essential' training document was completed by clinicians annually and at the time of our inspection staff achieved 91% compliance. Leaders told us the service aimed for 100% compliance with mandatory training but recognised due to the complexities of shared employment roles that this was not always achievable. Essential training included topics such as information governance, health and safety, manual handling, how to carry out daily checks and routines and fire safety.

Clinical staff completed training on recognising and responding to people with mental health needs, learning disabilities and people living with dementia. Data provided by the service following our inspection showed that 82% of staff received training in relation to supporting patients with mental health needs, 68% in relation to supporting patients

living with dementia and 61% compliance with learning disability training. Clinical staff used an online application which showed their training status, green for fully compliant and red requiring updates. Staff we spoke with told us they used this application at each shift handover as part of their check and challenge process to ensure theirs and their colleagues training was current, and they had the appropriate skills and competencies to meet the needs of the service.

Managers continually monitored mandatory training and alerted staff when they needed to update their training. Training compliance was a key theme in the services governance and quality processes and there were comprehensive systems for monitoring training linked to staff appraisals and the services strategic objectives. The service had systems in place to ensure staff did not work on front line shifts in emergency settings unless they had completed mandatory training elements.

If staff were not deployed and they had completed checks on equipment and admin roles were complete, they would engage in training activities daily to ensure they were up to date with best practice. The service had invested in a range of training resources, had a training room and provided training to external stakeholders, for example the police.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. The service had an up-to-date safeguarding policy that covered both adults and children with clearly defined roles and responsibilities in relation to the safeguarding referral process. As the service responded to 2 main NHS trusts as part of its urgent and emergency care deployment, staff had access to the safeguarding single point of contact for both of the trusts to refer safeguarding concerns directly to them.

Staff received training specific for their role on how to recognise and report abuse. All clinical staff had completed level 3 safeguarding adults and children training. This was in line with the intercollegiate document *Adult Safeguarding: Roles and Competencies for Health Care Staff 2019*. All other staff and volunteers completed safeguarding training at level 1 and received updates at appropriate levels and in line with their roles and responsibilities.

The service had a dedicated safeguarding lead trained to level 3 safeguarding in adults and children, with links to local safeguarding networks to gather additional updates on safeguarding practice. The services safeguarding lead reviewed all patient records to establish if there were any safeguarding concerns and ensure a safeguarding referral had been made and ensure that staff had received appropriate support and the safeguarding process was completed effectively.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the *Equality Act 2010*. Staff we spoke with clearly explained how they placed patients at the centre of the safeguarding process and were clear on their roles and responsibilities. They also considered contextualised safeguarding for others likely to be affected in a safeguarding situation. For example, where people may have taken an overdose with a child in the home, or where a patient may be self-neglecting and putting other family members at risk. Staff we spoke with showed genuine compassion and understanding for vulnerable people, and how to recognise the signs of abuse in adults and children.

Staff knew how to make a safeguarding referral, who to inform if they had concerns including how to contact the safeguarding single point of contact to make a safeguarding referral. Staff had experience and training in meeting the needs of patients who may lack capacity and who may need additional support to consent to their treatment to keep them safe.

Outstanding ☆

Emergency and urgent care

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 and the premises visibly clean.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We looked at 1 air ambulance and 3 ground vehicles all of which were visibly clean, staff records we reviewed showed they had been cleaned in line with the services infection, prevention and control (IPC) policy. Staff used the services electronic recording system each time they carried out their daily cleaning. Cleaning logs were centralised, and reports were reviewed by leaders and the clinical governance team to ensure compliance with the required standards had been met.

The service performed well for cleanliness. We looked at cleaning logs of the service's base and vehicles, staff had fully completed these and the location was visibly clean when we visited. Records showed that in July 2022, the service achieved 100% in all areas of the base and its vehicles for hygiene and IPC audits.

Staff followed IPC procedures including the use of personal protective equipment (PPE) and 77% of staff had achieved compliance with IPC training level two. Staff we spoke with had a comprehensive knowledge of the services IPC processes. The service's IPC policy was up to date, and reflected current guidance in relation to infection control, including COVID-19. Staff had access to a wide range of personal protective equipment, handwashing facilities, sanitisers and antibacterial wipes carried in a grab bag for each vehicle. Hand sanitisers were readily available throughout the location, and staff told us they used hand gel and sanitisers before and after every episode of direct patient contact and they could complete full hygiene routines at the local hospitals.

As part of the staff shift handover checklist, the service asked the clinical team members to confirm they had cleaned their hands, and this was captured digitally as part of a check list at every staff handover. Data collected by the service in the 3 months before our inspection in September 2022, showed that of the 199 checklist completed staff achieved 88% compliance with hand sanitising at the beginning of the shift. To improve this compliance the service altered the checklist to make hand cleaning a 'must complete' item before being able to move on further into the handover checklist.

During our inspection we spoke with an external stakeholder who told us the service had been instrumental in helping them to identify best practice in relation to IPC during the COVID-19 pandemic to ensure people were not put at risk.

The service had a deep clean programme for the rapid response vehicles and the air ambulance was cleaned in line with strict aviation protocols and policies, pilots had overall responsibility for ensuring the air ambulance was ready for any mission and cleaned appropriately before a flight. Staff told us they cleaned all equipment after each use and before leaving the base so that all equipment was clean when arriving at the scene with the patient.

Staff wore uniforms and the service had effective processes to maintain standards of cleanliness and hygiene when decontaminating uniforms. The service had a dedicated sluice area and a bespoke decontamination pod. The decontamination pod system gave the service the ability to decontaminate medical equipment and personal protective equipment to the highest standards. The system utilised a dry system, with low concentration hydrogen peroxide as a very effective decontamination system. This system was effective against extremely difficult to kill pathogens, well over and above Corona Virus type organisms.

Sterile consumables were stored correctly and safely. We checked 20 sterile consumables which were all sealed and in date. All consumables were kept in lidded boxes to prevent dust contamination.

Environment and equipment

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

The design of the environment followed national guidance. The existing location was appropriate for the services delivered, but leaders had identified the need to relocate the service as the environment needed significant investment to meet the future demands of the service and improve the quality of resources. Leaders we spoke with told us that the service was moving to a new location in June 2023, which was being custom designed to meet the future demands of the service and incorporate new technology and designs to enhance the provision. The location had dedicated office and training spaces, and aircraft hangar with additional prefabricated pods inside to store additional equipment. Leaders had sought feedback from staff to make improvements at its existing location including redecoration, updates to lighting and IT systems. They also sought feedback from the staff, volunteers and wider stakeholders regarding plans for the future headquarters.

Staff carried out daily safety checks of specialist equipment in order to keep people safe and records from July 2022, showed staff achieved 100% compliance with safety checks. The service kept an electronic record of all equipment checks carried out by staff, and records we reviewed showed that checks were completed, and records were scrutinised by managers and the services clinical governance team. Equipment storage areas were well organised, visibly clean and there were clear processes for reporting and removing any defective equipment to prevent them remaining in use.

The service had enough suitable equipment to help them to safely care for patients. The service used a wide range of equipment for adults and children, which was up to date and service record showed they had been reviewed for safety checks in line with manufacturer guidance. Vehicles were stored safely when not in use, areas were alarmed with keypad-controlled entry and vehicle keys were stored safely inside the base. Due to the development of new services in Luton the service had purchased a new rapid response vehicle (RRV) selected for its size, safety record and advanced capabilities.

The service had access to advanced technical equipment. The service used night vision goggles, so the pilots and clinical staff could effectively respond to calls by air, between dusk and dawn when lighting was restricted.

Staff disposed of clinical waste safely. Staff followed the services infection, prevention and control (IPC) policy in relation to clinical waste. Clinical waste was stored safely, including sharps and the service had a service level agreement with a local environmental service to remove and dispose of any clinical waste.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

The service provided pre-hospital emergency care to patients and due to the emergency service, they provided, staff could not carry out individual risk assessments for patients until they arrived on scene. The service was consistently looking at new methods of treatment and working on the leading edge of innovation to improve and implement their own guidance around patient risk. Staff we spoke with told us they were taking high level critical care training, equipment and techniques to an emergency to provide lifesaving treatment.

Outstanding ☆

Emergency and urgent care

The service had a wide range of standard operating procedures, based on current clinical research, best practice and guidance to support clinicians to assess and respond to patient risks. Critical care paramedics and doctors risk assessed patients using theses standard operating procedures, for example, to assess for cardiac arrest, spinal injury, major haemorrhage, or head injury, amongst others, all based on best current practice models.

The service managed risks proactively and positively. Clinicians routinely performed 'check and challenge' activities to challenge each other and to establish if there were alternative methods of assessment, treatment or care available to improve a patient's outcome. Staff we spoke with described a mature culture, that enabled staff to challenge each other positively, without fear of retribution in order to find the right assessment and treatment methods for the patient. This challenge and response created calm and control during busy environments and helped reduce the risk of human error. This ensured that everything was in place before performing a procedure or before leaving a scene.

Staff told us how they monitored vital observations continuously so they could quickly detect the deteriorating patient. Monitoring devices produced a graph that clearly showed the observations and any deterioration. This monitoring was constant and removed the risk of missing significant observations or patient deterioration during intervals of care.

The main patient groups attended by the service were those in or after cardiac arrest and those with serious injuries. As a clinical service responding to 2 local NHS ambulance trusts for their sickest patients the team were able to focus on the needs of a single patient by ensuring they had a senior two-person clinical team attend to each patient, providing 2 to 1 care in many cases. Data supplied by the service following our inspection showed 64% of staff were compliant with advanced paediatric life support training, 66% were compliant with advanced trauma life support, European trauma course and pre-hospital trauma life support. Staff achieved 71% compliance with basic life support and 77% with advanced life support. However, the clinical team followed a raft of royal college of emergency medicine (RCEM) guidance, were highly skilled and followed standard operating procedures that gave high levels of critical intensive care treatment on a day to day basis. Leaders told us that clinical practices were often far in advance of the highest levels of life saving training and they practised these daily.

The clinical team carried 2 types of antibiotics one for open fractures and chest wounds/open thoracostomies, (Surgical opening of the chest, as for drainage) and one for suspected meningococcal meningitis (Meningococcal meningitis is *a rare but serious bacterial infection*). The service audited the use of these and an action plan from the open fracture antibiotic use was completed and reviewed by the service's clinical governance committee. Paramedic staff were trained in the recognition of sepsis through their NHS employer and treated sepsis in line with guidance in the joint royal colleges ambulance liaison committee (JRCALC) protocols. At the time of our inspection 75% of staff had completed training in the recognition and treatment of sepsis.

The service had a duty advice doctor which enabled staff on scene to request additional clinical advice by telephone or video calls 24 hours a day from a consultant / doctor either at base or on call to help assess or treat a patient's condition. Staff used this process to get additional clinical advice when on scene and during patient transit. Staff told us this support was effective and made a positive contribution to patient care.

There was a safe and effective escalation process for deteriorating patients or situations that were beyond the abilities of staff. Additional resources could be requested through the helicopter emergency medical service (HEMS) desk for the East Midlands region or critical care desk in the East of England. In most circumstances, the HEMS were the most competent team to manage the seriously ill patient in the pre-hospital setting. Additional resources were requested if the number of patients was too high for a single HEMS team to manage safely.

Staff knew about and dealt with any specific risk issues and took a proactive approach to anticipating and managing risks to people. There was an embedded culture that recognised risk reduction was the responsibility of all staff. Before high-risk interventions, staff could rapidly anaesthetise and manage the airway of a patient which meant staff could carry out high risk procedures in a controlled manner.

Due to night operations the teams had additional check and challenge processes to promote safety on missions, including pre-flight checks, a more detailed review of the location and environment. Staff used learning from the simulations and openly discussed and challenged each other to anticipate and manage risks to people during their daily shift handovers and all staff recognised risk and safety was their responsibility.

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 staffing levels and skill mix and gave staff a full induction.

The service had enough staff to keep patients safe and managers accurately calculated and reviewed the number and grade of staff in accordance with national guidance. They had enough paramedics, doctors and pilots to cover shifts 24 hours a day, 7 days a week, this consisted of a pilot, technical crew, a critical care paramedic (CCP) and a doctor on duty.

The service launched a solo paramedic shift into its staffing rotas in May 2022 and in its first three months, the paramedics covered 24 shifts, were activated to 40 incidents, and saw 24 patients. Solo paramedic shifts enable the service to offer more patients advanced care on occasions when shifts may have been dropped due to a lack of 2 staff to provide the service. At the time of our inspection the service was further developing the advanced paramedic role and the advanced paramedic career pathway to enable the service to provide more patients with advanced care when they need it.

The service employed all of its non- clinical staff, however, all clinical staff worked within other NHS trusts and worked with the service under memorandums of understanding. The East of England Deanery placed some pre-hospital emergency medicine (PHEM) doctors with the service as part of their PHEM sub-speciality training, following which they moved onto another service. Data provided by the service following our inspection showed that all staff received a comprehensive induction that covered a wide range of the services training and key details in relation to the service.

Thirty-one doctors and 13 paramedics worked within the service, managers ensured there were always enough staff available to deliver the service and tracked all shifts to ensure compliance against its staffing standards. Rotas and shift patterns were aligned so shift times overlapped to ensure resources were available to meet demand. The overlap meant there was never a time where staff were handing over shifts without other staff available to respond to emergency calls.

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. At the time of our inspection the service had no vacancies for clinical staff. Between 1 September 2021 and 31 August 2022, the service had low sickness rates of 1.2% for doctors and 1.6% for paramedics.

As art of the memorandum of understanding with the NHS trusts, the service's paramedics were employed on three-year secondments from other NHS trust's, the pre-hospital emergency medicine trainees (PHEM) were employed on either 6month whole time or 12 months split between PHEM and an emergency department at other NHS trusts. Senior

clinical fellows were employed on a 12-month fixed term contract. Records we reviewed with the services operations team at the time of our inspection showed the service had comprehensive systems for managing staff hours, maintaining records in relation to training, skills and staff competencies to ensure managers could deploy competent trained staff onto the duty rota.

The service was working in partnership with the paediatric and neonatal decision support and retrieval service (PaNDR) and offered senior doctors within the service a 50:50 split role working with the services HEMS team and with PaNDR. PaNDR provides critical care retrievals for children up to the age of 16 years requiring transfer from 15 hospitals across the East of England with 3 paediatric teams in operation 24 hours a day, 365 days a year.

As the service was a registered charity, it had volunteers and a dedicated fundraising team to generate income and support the charities vision and mission.

Air ambulance pilots and technical crews were under a subcontract with a specialist aviation service, but they were seen by all staff as part of the services core team of staff and integral to providing pre-hospital emergency medicine. Managers told us that relationships with the external contractor and the pilots and technical crew were extremely positive and that they worked closely together to maintain pilot coverage.

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. The service had moved onto an electronic patient care record (EPCR) system and staff completed records using an electronic tablet. We reviewed 15 patient records that demonstrated staff had completed them clearly with medicines and interventions clearly recorded. Each time a patient record was completed, this was reviewed by the doctor of the day as part of the service's clinical governance processes. This enabled the service to scrutinise and challenge records to ensure they were completed to the required standard. It also promoted discussion between clinicians to review the care delivered and establish if this had been effective or if alternate methods could have been used to promote patient safety and manage risks. The service's safeguarding lead reviewed all patient records to establish if there were any safeguarding concerns and ensure a safeguarding referral had been made. They also ensured that staff had received appropriate support and the safeguarding process was completed effectively.

The electronic record system enabled staff to manage and share the information that was needed to deliver effective care treatment and support, and was coordinated to provide real-time information across services, and support care for people who use services. The service had information sharing arrangements with other health care providers and a named professional to ensure that information met the information commissioner's office (ICO) information requirements relating to public interest, promoting openness by public bodies and data privacy for individuals.

When patients transferred to a new team, there were no delays in staff accessing their records. Arrangements for recording decisions were clear, and transfer locations were clearly noted in the patient clinical record.

Records were stored securely and there was a process in place for the management of confidential waste as part of a service level agreement with an external contractor.

Staff told us they would always seek to establish the resuscitation status for all patients, including if the patient had a do not attempt cardiovascular resuscitation (DNACPR) or recommended summary plan for emergency care and

treatment(ReSPECT) form in place. This meant that if a person has a cardiac arrest or died suddenly, there was guidance on what action should or should not be taken by a healthcare professional, including not performing cardiopulmonary resuscitation (CPR) on the person. Staff told us they would liaise with family members where possible or seek advice from the local NHS ambulance service who could access some of the patient records online at scene. The service was working with its NHS partners to establish if it could access online patient records directly, this work was in progress at the time of our inspection.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. There was a formulary in place for the medicines used by the service, this was approved and reviewed by the clinical governance committee (CGC). The CGC held overall responsibility for establishing and maintaining the safe and secure handling of medicines. The service used an electronic system to record details of missions. We looked at 3 patient records and saw that medicines had been prescribed, administered and recorded in line with provider policies and national guidance.

Clinical decision support tools were regularly updated in line with national guidance or available evidence and were easily accessible by staff. The service recently developed a clinical guide to support the safe prescribing and administration of medicines for children.

The service continuously reviewed their processes to improve the safety of medicines administration. To minimise the likelihood of errors occurring with the use of neuromuscular blocking agents in emergency anaesthesia, the service used colour coded syringes to draw up these agents.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines throughout their conveyance. Staff monitored continuously the effects of any medicine they administered until the point of conveying the patient to hospital.

Staff completed medicines records accurately and kept them up to date. The service provided the electronic patient record to the receiving hospital within 30 minutes of completing the mission. This meant the hospital could continue treatment appropriately as they had records of medicines which the crew had administered. A consultant reviewed regularly the records of missions carried out to ensure medicines had been prescribed and administered appropriately. Clinical staff met monthly to review cases and share learning between them.

Staff stored and managed all medicines and prescribing documents safely. Medicines and controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely. There was an alarm in the aircraft hangar where medicines were stored which would alert staff to any unauthorised access and 24-hour CCTV was in operation. Grab bags which contained medicines were also stored securely in the medicine's storeroom and taken out when the crew were tasked with a mission. They used traceable tamper-evident tags to seal grab bags to ensure medicines are available when needed and fit for use. During a mission a doctor and a paramedic also carried some emergency medicines in a rolled bag attached to them. These rolled bags had additional locator tags to be able to track them in case of loss.

The service ensured medicines were stored at the recommended room or fridge temperatures. Staff sought advice from manufacturers before amending the shelf life of medicines stored outside the recommended refrigeration requirements. Oxygen cylinders were stored in a purpose-built locked storage unit which allowed them to be kept clean and dry. Cylinders were clearly labelled if they were full or empty and any safety warnings were clearly displayed.

There were appropriate systems in place for the safe disposal of medicines and destruction of controlled drugs. The chief executive officer was an authorised person to witness the destruction of controlled drugs and the service had a T28 waste exemption certificate for this from the environmental agency.

Staff carried out regular checks and audits on the safe and secure management of medicines including controlled drugs.

Staff followed national best practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff used multiple sources, including photographic evidence to obtain accurate information on the current medicines a person was taking. They recorded this information on the electronic patient record which was shared with the other services when care was transferred.

Staff learned from safety alerts and incidents to improve practice. There were robust systems in place for reporting incidents and for receiving and dealing with medicines safety alerts. All reported incidents involving medicines were investigated by the medical director and discussed at the clinical governance committee meetings. Learning was shared in multiple ways with staff members. Staff gave us examples of recent incidents and knew what changes had been made in practice as a result of these.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. There was a process in place for raising concerns internally and escalating any issues externally, where necessary. We reviewed an incident which was reported to the relevant safeguarding team for investigation. The incident involved a patient not receiving their medicines appropriately by another organisation and this was identified during a mission.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with knew what incidents to report and how to report them. We reviewed the service's incident reporting policy that was up-to-date and had a date to be reviewed. Staff we spoke with told us they knew how to report incidents through the service's intranet which was accessible from computers at the location or by mobile devices whilst at scenes.

Staff reported serious incidents clearly and in line with the service policy. We reviewed incident feedback contained within governance reports which showed staff raised concerns and reported incidents and near misses in line with the services incident reporting policy. Incidents were risk rated and investigated by trained and competent staff, who had experience and knowledge related to the type of incident that occurred.

Data supplied by the service following our inspection showed that between 1 September 2021 and 31 August 2022, staff reported 83 incidents in line the service's incident reporting policy. Most incidents related to medical equipment and devices with 45 incidents reported. Eight incidents were in relation to medicines, 8 with regard to communications and tasking, 7 clinical incidents, 6 involving other ops, 5 related to the rapid response vehicle (RRV). There were 2 incidents regarding support vehicles, and 2 in relation to corporate and headquarters. Staff we spoke with told us that they received feedback from reporting incidents in their staff forums, from clinical governance meeting records and that the

service was quick to respond to incident reports in order to make changes or replace equipment. Incident details were also available to staff on team reads, (information specifically shared with the team on important operational matters), the services intranet, during shift handovers and on a one to one basis if the staff requested direct feedback from the investigator.

Staff were aware of safety reports from national reporting bodies. These national bodies share feedback on events that have happened in other services to minimise risks to other people, for example if there was a piece of equipment that was likely to fail or a risk to people associated with a certain type of equipment.

Staff told us they worked within and were supported by an "Incident learning culture." The service had a sustained track record of safety and used accurate performance information to consistently improve its services and make progress towards safety goals. Staff told us this was influenced by the training and learning they received and from incidents shared by the aviation teams, who promoted a no blame and "just culture" in relation to incidents.

The service's medical director reviewed all incidents, took appropriate action to investigate incidents, and recorded any learning or actions taken from the investigation process. Where appropriate, the service requested patients, relatives and other organisations to participate in investigations where they had been involved. The medical director had received training and had significant experience in relation to route cause analysis and carrying out investigations.

Staff understood duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff we spoke with fully understood the role of duty of candour in relation to incidents and the service's complaints policy included duty of candour, and the need to be open and honest when things had gone wrong.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at handovers, in team meetings, and clinical governance meetings. Staff used feedback from incidents and created training scenarios to ensure staff understood what had gone wrong, learn from this and minimise events in the future.

Managers debriefed and supported staff after any serious incident. The service had comprehensive systems to support staff and a debrief took place after ever mission where staff could discuss incidents and make immediate changes to reduce any ongoing risks within the service.

Clinical staff we spoke with told us how important the pilots and technical teams were in incidents, as they often had an overview of a situation as they weren't involved in the hands on clinical care and had a wider perspective of what was happening on scene.

We spoke with external stakeholders who told us they were actively engaged in incident reviews and learning from incidents was shared across the urgent and emergency care sector in order to minimise risks to other people. One stakeholder told us that the learning from the service had been instrumental in how they had gone on to develop their response to incidents and the management of clinical risks.

Are Emergency and urgent care effective?

Outstanding ☆

We have not previously rated this service. We rated it as outstanding.

Outstanding ☆

Emergency and urgent care

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 and procedures to plan and deliver high quality care according to best practice and national guidance. Policies and standard operating procedures reflected up-to-date and relevant legislation and guidance set out by relevant national public bodies and committees including *The National Institute for Health and Care Excellence (NICE) and NHS England.*

Staff we spoke with explained how they worked to service guidelines and could seek advice from the service's medical director and access policies and standard operating procedures remotely through their IT tablets. We reviewed 9 of the service's standard operating procedures and policies, all of which were in date, had a date for review, a procedure owner and referenced current best practice in pre-hospital emergency medicine (PHEM). The service used and participated in research to good practice standards in relation to national guidance and contribute to research and development of national guidance and share this with other PHEM services across the region. One of the services strategic goals was to identify, obtain and share evidence and research to improve quality, effectiveness and ensuring patients have the ability and opportunity to engage and provide feedback.

On induction, the service sent out all standard operating procedures and policies to new staff. Policies and procedures were shared on the services intranet and leaders shared updates by using the team reads process.

Care was regularly monitored to ensure it was in line with evidence based, guidance, standards and best practice. Each time a patient record was completed, this was reviewed by the duty advice doctor to ensure staff provided care and treatment based on current national guidance and evidence-based practice. Leaders consistently monitored risks and used research to enable innovative care and treatment to patients.

External stakeholders we spoke with told us the service's leadership and staff teams were always willing to adopt new evidence-based practise and work in partnership to improve patient outcomes.

Staff used a number of checklists to improve patient safety including a check list for patient post return of spontaneous circulation (ROSC), procedural sedation, emergency action, paediatric cardiac arrest, and a casevac (casualty evacuation) checklist. The service developed these checklists and refined them based on urgent and emergency care literature reviews, staff simulations of urgent and emergency scenarios and on feedback from incident reviews. The clinical team were trained to use the checklists in teams of 2 as a challenge response checklist with the majority of answers being a 'yes' or 'no'. In the pre-hospital emergency care situations, staff did not keep records of the responses, staff immediately acted upon the checklist answers. The service has previously published research on the effectiveness of the checklists in peer reviewed journals.

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 using a nationally recognised tool and gave pain relief in line with individual needs and best practice. Staff told us they used a pain scale of 1 to 10; 1 being very little pain and 10 being the worst pain possible. However, they also told us most patients were unable to communicate their pain due to being seriously injured.

Staff selected the least invasive pain relief as a first option, especially with children, who were often very frightened in an emergency and needed a great deal of reassurance. Staff could use oral medicines or intravenous medicines dependent on the level and nature of the pain. Staff used the 1 to 10 scale for older children and accessed smiley face pain scores on their IT tablets if necessary, to help children identify their pain levels. Staff also explained how they may use small portable torches to distract children whilst they were carrying out procedures or administering pain relief.

Staff also assessed patients by looking at the quality and nature of pain by assessing the type of injury, body language and physiological signs, for example, increased blood pressure, respiratory rate and heart rate. The staff had access to strong pain-relieving medicines that a standard ambulance service was unable to offer. This ensured patients were kept as comfortable as possible.

Patients received pain relief soon after it was identified they needed it or if they requested. Suitably qualified staff administered and recorded pain relief accurately. We reviewed 15 patient records, 7 of the records showed that patients had required pain relief. In these cases, the patient record showed that staff had delivered pain relief and given additional pain relief where necessary and medicines records were completed accurately.

Staff carried out pre-flight checks, including medicines and had pre-drawn up pain relief to enable staff to deliver this quickly and easily to patients either on scene or during a flight to a hospital.

Patient outcomes

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

The service participated in relevant national clinical audits. Staff we spoke with during our inspection told us they actively participated in audit and viewed this as an opportunity to further improve services, build on their own skills, knowledge and competencies whilst improving outcomes for patients. Data from audit outcomes was shared across the service, and with external stakeholders. The service's trustees routinely reviewed key performance indicators (KPI) that included patient outcome data.

The service was actively involved in research and audit in order to improve patient outcomes. Outcomes for patients were positive, consistent and met expectations, such as national standards. The service routinely collected and monitored information about people's care and treatment, and their outcomes. This information was used to establish if care had been effective, and what impact the care and treatment had on patients longer term outcomes. The service participated in local and national audit and research to assess the effectiveness of care given on scene and how that care influenced patient outcomes, shared this with other hospital emergency services and external stakeholders to make improvements in the service.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Audit was seen by the team as key to driving improvement and learning when things didn't go as planned. We reviewed a wide range of audit data, including audits on infection prevention and control, medicines, vehicle safety and staff training amongst others. All the audit data was accessible to the services wider team, and there was an open culture of challenge around audit to ensure they were effective and had impact on patient outcomes.

Improvement was checked and monitored. Audit data was scrutinised by front line staff, managers, the clinical governance team and governance processes and KPI from audit was routinely reviewed by the services trustees.

Emergency and urgent care

Managers shared and made sure staff understood information from the audits.The service was committed to learning from audit and had a dedicated audit schedule overseen by the leadership and governance teams. Audits included, but were not limited to, antibiotic use re-audit, return of patient spontaneous recirculation audit, thrombolysis audit, and the benefit of hospital emergency medical services audit. We reviewed a learning forum record from April 2022, that showed how managers shared learning from audits with the wider team in order to improve patient outcomes.

The service had recently published research in relation to the *Comparison of deliberate self-harm incidents attended by Helicopter Emergency Medical Services before and during the first wave of COVID-19 in the East of England.* This showed the significant increase in these incidents over COVID-19 across three services in the East region.

Other research that impacted on patient outcomes included, *Intubation success in prehospital emergency anaesthesia: a retrospective observational analysis of the Inter-Changeable Operator Model (ICOM).* This analysed outcomes between different urgent and emergency care service operators intubating patients across 2 services in the East region and showed no difference and a very high success rate, reinforcing the safe system for patients.

At the time of our inspection the service was involved in developing a national pre-hospital research and audit network (PRANA). This was collaborative comparative outcome data used across the NHS, for example the intensive care national audit and research centre (ICNARC) for intensive care patients or trauma audit and research network (TARN) for major trauma patients. The services lead for clinical effectiveness was one of the leads for developing a pre-hospital equivalent to ICNARC – PRANA and leaders told us this will be a significant development in pre-hospital outcome analysis in the UK.

The service was waiting publication of one of its other research projects, *Predictors of post-pre-hospital emergency anaesthesia hypotension (PHEA) in trauma patients across the East of England*. This study looked for both predictors of hypotension and outcomes. The study showed that drugs were unlikely to be responsible but independent predictors were the patients age was greater than 55 years, heart rate and Glasgow coma scale (GCS). When compared to the 2 other urgent and emergency services, patients using this service were associated with a better outcome.

Staff were trained in the use of point of care ultrasound (POCUS) for optimising percutaneous vascular access for invasive monitoring during the intra and peri-arrest phases of patient care to improve patient outcomes in an emergency.

Staff conducted clinical audits to improve the quality of their service and shared findings with other providers. The provider undertook an audit recently to evaluate the effectiveness of an emergency pain relief medicine and made improvements to their process when using this.

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. The service worked with stakeholders to ensure staff had the necessary skills, knowledge and behaviours appropriate to their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had a highly skilled, competent and trained workforce that was focused on providing high-quality care, using up to date research and training to support people and each other. The operations team worked alongside managers to ensure records in relation to staff were comprehensive. We reviewed the staff data set held by the operations team which demonstrated appropriate references and disclosure and barring service (DBS) checks had been completed for all staff.

Emergency and urgent care

Managers gave all new staff a full induction tailored to their role before they started work. The service had comprehensive processes for checking people had the right to work in the UK, identify previous disciplinary concerns and ensure staff had completed the appropriate levels of training and competency frameworks.

Clinical staff we spoke with told us the service provided them with an individual training budget, which they could spend on additional training over and above the mandatory and expected training in order to improve their skills, knowledge and competencies. They would discuss this with their appropriate manager and agree how the training would benefit people who used the service. Staff told us this process was positive for them and showed that leaders invested in the staff to support their skills and to achieve positive outcomes for patients.

Managers supported staff to develop through yearly, constructive appraisals of their work. As the clinical staff were not directly employed by the service, leaders had developed a memorandum of understanding with the staff's main NHS employers regarding their employment. This enabled clinical staff to receive an appropriate appraisal with joined up development targets across the services. We spoke with leaders from one NHS trust who told us the memorandum of understanding worked effectively and enabled staff to experience joint working and appropriate levels of training and development to the staff team.

Doctors within the service had an NHS employer as their designated body through which they received their appraisal. The service provided an additional scope of work statement for this purpose and multi-source feedback questionnaires completed by team members during employment. Paramedics participated in an annual 'compassionate conversations' (ambulance service appraisal process) along with multi-source feedback questionnaires completed by team members during employment. Non-clinical staff received an annual appraisal annually in June.

The service actively sought feedback on staff performance from external stakeholders, which they collated and reviewed to ensure staff met the required service and professional standards. Staff we spoke with described how the service used multi-source feedback, which could be sent from any professional, work colleagues, another service on site, for example other NHS ambulance services. We reviewed multi-source feedback from July 2022 which said, "The clinical knowledge is excellent", another said, "Gives great direction on scene and drives team cohesion." Other feedback included, "Strong knowledge of standard operating procedures" and "Paramedic has been extremely supportive to new paramedics joining the team."

At the time of our inspection 92% of doctors and 100% of paramedics and non-clinical staff had received an appraisal. The appraisal system was linked to training and development activities and performance targets aligned to the services strategic objectives. If staff were not compliant in any areas of training, they would not be able to complete their appraisal, and staff we spoke with confirmed they would be held back from their front-line duties until they had completed all the necessary updates.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with told us that appraisals were constructive and provided an opportunity to discuss additional training. Managers made sure staff received any specialist training for their role or research outcomes in pre-hospital emergency medicine. Managers had access to live data on training compliance through the service's intranet system and staff we spoke with told us managers valued their training and encouraged them to take on additional skills and knowledge.

The service offered a comprehensive teaching package to fellows and medical trainees covering core aspects of the sub-specialty, including respiratory, cardiac, surgical, infection and complex airways. Managers supported clinical staff to develop through regular, constructive clinical supervision of their work in partnership with their NHS employer.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers could also base training on analysis and investigation of things that went wrong, for example incidents. Leaders encouraged staff to participate in learning to improve safety as much as possible, including working with others in the urgent and emergency care system and participating in local, national, and international safety programmes. Managers also offered staff opportunities to learn from external safety events, for example from their aviation providers and national safety alerts.

The service's medical director was its responsible officer (RO). The RO was a senior clinician who ensured that the doctors for whom they acted in this nominated capacity, continued to practice safely and were properly supported and managed in maintaining their professional standards and general medical council (GMC) registration They also ensured they were meeting appraisals and supervision standards and managed any allegations against medical staff.

The service ensured any staff required to drive the rapid response vehicles under blue light situations were appropriately trained and the operations team maintained a central record of staff blue light training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Due to the nature of pre-hospital emergency medicine, the service team worked with a wide range of other professional staff including the police, fire and rescue services, ambulance staff, hospital staff and after care services. Staff described positive working relationships with other multidisciplinary staff to benefit patient outcomes and save lives and limit the impact of life changing events.

External stakeholders we spoke with described mutually respectful working between the staff disciplines in order to benefit people. They described staff as willing to quickly integrate into larger teams to extract patients from complex emergency scenes and share expertise to improve patient outcomes.

Staff worked together and agreed plans to transport the patient. Before transporting a patient, staff communicated with the other teams to discuss the best method of extraction. Staff would communicate where the patient would be transported to, the method of transport and then confirmed that all involved were happy with that decision before making the extraction. The pilots and technical air crew were highly valued members of the services team, ensuring that safety and site integrity were maintained at all times.

The service was a member of the Air Ambulance UK. This gave the service an opportunity to share best practice and guidance with other similar services across the UK.

Seven-day services

Key services were available 7 days a week to support timely patient care.

The service operated 24 hours a day, 365 days a year using its air ambulance between 7am and 7pm and rapid response vehicles (RRV) operated 24 hours a day.

Emergency and urgent care

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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 we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood their role and responsibility in relation to patient capacity and consent and were able to explain how they used the services up to date consent and capacity policies to guide their activities on scene.

Staff told us they always sought consent from patients for their care and treatment in line with legislation and guidance. Patients and the relative we spoke with during our inspection told us that staff involved them in decisions about their care and sought consent before and during care and treatment.

Staff had a good understanding of the Mental Capacity Act 2005 and acted in the patient's best interests if they were unable to consent. Clinical staff had completed training on the Mental Capacity Act and dementia, which was part of safeguarding training to ensure they understood the needs of people who may become more vulnerable due to the nature of the emergency.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff we spoke with told us they would involve patients in decision making and support them by explaining complex medical information in simpler ways, using note pads, hand gestures or access online translation tools for patients whose first language was not English.

Staff told us they sometimes relied on relatives at the scene for additional support and information regarding the patient's condition, to establish whether the patient was living with dementia or had other mental health conditions. Staff also liaised with other emergency services on scene to gather information, assess what had happened and gain additional details regarding the patient's condition and ability to consent to care or treatment. This included establishing if the patient had made an advance decision in relation to their do not attempt cardiovascular resuscitation (DNACPR) status or recommended summary plan for emergency care and treatment (ReSPECT).

Staff explained how they would manage fluctuating capacity and the need for immediate sedation if a patient had delirium or could cause additional harm to themselves or others if they weren't immobilised on scene. The service had an up to date medicines policies in place, which included the least restrictive methods for restraining a patient through sedation.

Staff made sure that where patients could, they consented to treatment based on all the information available and patient records we reviewed showed staff recorded patient consent. We spoke with one patient who told us the staff had been clear on the actions they were taking and sought their consent before treatment. Another patient told us that staff had spoken to them clearly and ensured they fully understood what was happening and involved them in decisions about their care, checking that the patient had capacity routinely through their treatment and extraction from the scene of the emergency.

Staff understood the relevant consent and decision-making requirements of legislation and guidance and they knew who to contact for advice. Staff described how to access policies and guidance on the Mental Capacity Act 2005 on the service intranet which they could access whilst on scene. Staff could also contact the medical director or duty advice doctor for additional advice on any areas of capacity or consent whilst on scene.

Outstanding ☆

Emergency and urgent care

Are Emergency and urgent care caring?

Outstanding ☆

We have not previously rated this service. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients we spoke with told us that staff were discreet and responsive when caring for them. During our inspection when speaking with staff, volunteers, patients and relatives we noted a strong, visible person-centred culture. Staff we spoke with were highly motivated and inspired to offer care that was kind and promoted people's dignity and wanted to ensure peoples' privacy and dignity was consistently embedded in everything they did.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients we spoke with told us staff treated them well, with professionalism and kindness. During our inspection we spoke with 7 patients and 1 relative. Feedback from people who used the service and those who were close to them was continually positive about the way staff treated and supported them. They told us that staff had exceeded their expectations, respected their dignity and privacy and offered them kindness and compassion.

Following and during our inspection we reviewed a range of written feedback from patients and relatives. One relative said, "I was just like to place on record how very grateful I am to the team who saved my relatives life" another relative said, "An excellent service and I feel blessed to have the team, they saved my relative."

One relative's feedback said, "Knowing that you tried everything you could, gives me some comfort and your families must be so proud of you."

Often due to the nature of patient injuries or relatives not being on scene they could not remember or be involved in the treatment provided by staff. However, all the patients and relative we spoke with told us they had had the opportunity to meet the staff involved in their care and treatment as part of their rehabilitation and this was important to them in their recovery process.

One patient we spoke with said, "It was like the angels were coming down from the sky, they saved my life, I am only here because of them." Another patient said, "They are truly amazing, and so humble, they really are just the best at what they do."

A relative said, "I didn't see what happened, but the support and care our relative received was outstanding, they really do care. One of the staff who treated our relative came all the way from Blackpool just to see us after the emergency, they didn't have to do that at all, it just shows how much they care about people."

Another patient said, "I will never be able to say thank you enough, they are so professional and offer the best care ever."

Staff told us they would speak with relatives on scene who may have witnessed the incident in order to fully ensure that the patient needs were met. Patients and relatives told us the teams involved in their care were outstanding, describing staff as “superheroes” and “amazing.” They told us that the staff offered care that was kind, respected their preferences and needs.

Often patients and relatives became volunteers and advocates for the service based on their experience of care and wanted to ensure that others received the same level of kindness and support.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff made sure patients and those close to them understood their care and treatment. One patient we spoke with said, “I couldn’t believe what was happening, I thought I was going to die, the doctor that saved me was amazing, they gave me reassurance and explained everything that was happening, I am sure I only survived due to the actions of the staff and the way they managed my care.” Another relative told us, “After we got to the hospital, we realised that the air ambulance team had waited with our relative until we arrived, we couldn’t believe they did that. They told us exactly what had happened, they were amazing given the situation, they fully explained things to us in a way we understood, they really did care about the whole family.” Another patient said, “It wasn’t until I spoke with the air ambulance team after my accident that I knew what had happened to me, and because of my experience I have become a volunteer and ambassador for the service, they are truly amazing, the whole team.”

Staff gave patients and those close to them comprehensive help, emotional support and advice when they needed it. Staff understood the needs of parents and their children. A relative told us about their experience of care, and how the team had supported their child during a life threating event. Staff had fully involved them in their child’s care and treatment at all stages and they felt reassured by the staff team.

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. Patients told us about meeting the staff that had provided them with care on the day of their injuries as part of their recovery. One patient told us that meeting the team helped them to fully understand what had happened, and to ask questions and thank the team that had saved their life.

The service welcomed patients and their relatives to become volunteers and to raise money for the service as a registered charity. Patients and relatives, we spoke with told us they found this experience highly rewarding and they felt like they were giving something back and contributing towards saving lives. One patient we spoke with told us about wanting to share their story and how they had gone on to write a book and donated the funds from the book to the charity. Other volunteers had climbed mountains and were planning fun runs, speaking at public events and delivering lifesaving first aid training in the community, all as a direct result of the service saving theirs or the lives of a loved one.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. One relative told us, “I didn’t see exactly what they did, I gave them space to do their initial treatment on our relative, but afterwards the staff told me exactly what had happened, the staff were amazing given the situation, they fully explained what they had done and

why." Another patient said, "They were just amazing, I knew I was in an impossible situation, in my mind I had already said goodbye to my family, that's how serious things were. But the doctor who came to me was just amazing, he explained exactly what was going to happen, we agreed together what the next steps would be and the professionalism was just out of this world, I would not be here without the air ambulance team, and that's a fact."

The service routinely sought feedback from patients and relatives as part of its patient's survey and asked if patients remembered being treated by the team, if they felt they were involved in their choices about care and treatment, if staff talked in a way they could understand, if they felt safe and if anything could have been done better. Feedback from the patient survey included one patient saying, "They were very kind and made me feel better, they made me laugh." Another said, "I want to thank the team who came out to my relative." The service's patient survey responses showed they felt involved in their care, that's staff talked to them in a way they understood, and patients felt safe during their treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff explained that in the many cases patients may not be able to communicate due to the nature of their condition, but staff explained the importance of still communicating with the patient as if they were conscious and explaining everything they were going to do. They could use their IT tablets to download pictures or write messages and or use signs and symbols to help patients understand what was happening.

One patient we spoke with said, "I was genuinely so scared, I could see my injury and knew how serious and painful it was. The team were so supportive and kind, I remember them saying, we will stay with you, we will be here until you are safe, we won't leave you. They didn't leave me and stayed with me until I was safe in hospital, I will never forget how kind and professional they were. I even got chance to meet them afterwards so they could answer any questions I had about what had happened to me."

Patients, relatives and bystanders could give feedback on the service and their treatment and the service team carried patient guides on the vehicles to give to people on scene where appropriate. The guides contained the service's contact details and explained how they could contact the service for advice and support following the emergency.

Staff supported patients to make informed decisions about their care. Staff told us they kept relatives and patients as informed about their care and treatment as possible. Records we reviewed showed that clinical staff often considered a range of options to meet patient needs. However, staff said that often their patients were unconscious or unable to understand what was happening on scene, so they had to make decisions in their best interest.

Are Emergency and urgent care responsive?

Outstanding ☆

We have not previously rated this service. We rated it as outstanding.

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.

Managers planned and organised services, so they met the needs of the local population. The service had a strategic objective to work with partners and stakeholders to deliver the highest standards of clinical care for patients in the

region. The leadership team held regular meetings with the chief executives of the NHS trusts across the East of England region to discuss demand and patient needs as well as meet with other emergency services for example the police and fire service. We reviewed the services strategic plan and objectives which included working with key stakeholders to ensure a regionally coordinated urgent and emergency care service, and to work with NHS partners to establish patient pathways and transfers.

The leadership team was highly committed to developing strong partnerships with external stakeholders to meet the needs of the local population. External stakeholders we spoke with described the service as highly responsive, willing to adopt new systems and processes and being genuinely committed to work within the wider urgent and emergency teams to provide seamless services.

The service used innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The service proactively engaged with other pre-hospital emergency services and acute NHS trusts to establish what the demand may be, where and when emergencies were likely to happen.

The service was in the process of building new facilities at a new location to provide new resources to its staff team and the public. Plans for the new facilities were well in advance at the time of our inspection and the location was due to open in June 2023.

One of the services key strategic objectives was to increase public awareness of immediate life support and cardiopulmonary resuscitation (CPR) in the community. It was committed to delivering training to as wide a public audience as possible in order to meet the needs of local people who may need support from community first responders or the public during a cardiac event. During 2021-2022, the service provided CPR training to over 3,340 people within the local community as part of its strategic objective to offer clinical training.

The service was working in partnership with the paediatric and neonatal decision support and retrieval service (PaNDR) to provide critical care retrievals for children up to the age of 16 years requiring transfer from 15 hospitals across the East of England with 3 paediatric teams in operation 24 hours a day, 365 days a year.

In September 2020, the service identified the need for a further team in the local area, and launched an additional RRV service in Luton, Bedfordshire operating 2 days a week. This service offered an advanced level of emergency medical care to the town and surrounding areas and improved response times by up to 40 minutes on average. The service was staffed by the existing critical care paramedics and doctors that operated from the services primary base at Wyton and a dedicated vehicle was provided for the Luton service which was funded through a grant provided by a local charitable organisation. The service told us that during the pilot scheme they covered 107 shifts, with 192 activations and treated 113 patients. However, as this service was launched during the COVID-19 pandemic the service has extended the pilot until 2024, to assess the use of the service post the COVID-19 pandemic.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. They coordinated care with other services and providers.

Staff made sure patients living with mental health conditions, learning disabilities and dementia received the necessary care to meet all their needs. Clinical staff had received additional training to enable them to meet the needs of people living with mental health problems, learning disabilities and dementia.

Outstanding ☆

Emergency and urgent care

Due to the nature of the service, a large proportion of patients had reduced levels of consciousness due to illness or injury on scene, therefore verbal communication was challenging for staff. Where possible staff used family members or friends to provide the initial information at the scene. Staff had access to online translation tools for patients whose first language was not English. Staff we spoke to told us how important this was in the emergency process in order to respect a person's faith or religion, be aware of any long-term health or disability that may affect the treatment plan for the patient.

Staff worked with other NHS trust staff and other emergency services when delivering urgent care, they worked alongside these services to access additional patient records, specialist equipment and specially trained staff who could deal with hazardous situations.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored response times and made sure patients could access emergency services when needed to receive appropriate treatment. People had access to the helicopter emergency medical service (HEMS) service when they needed it. Access to the service was by the 999 NHS emergency telephone line. People telephoned 999 and talked with the NHS ambulance service critical care team who liaised with the air ambulance teams to dispatch the most appropriate resources to the scene. The service operated its air ambulances seven days a week 365 days a year, between 7am and 7pm, supported by rapid response vehicles (RRVs) 24 hours a day.

Staff acted to minimise the time people had to wait for treatment. The service audited deployment times monthly using its key performance indicators (KPI). The service's KPI for deployment of the air ambulance was 6 minutes in the day and 10 minutes at night. The KPI for the deployment of the rapid response vehicles (RRVs) was within 3 minutes day or night. Between January 2022 and August 2022, air ambulance deployment times were within the KPI. During the same period the RRV achieved the KPI with the exception of April, May June and August 2022, where it was deployed on all occasions in less than 4 minutes. Managers worked closely with the staff and used audit KPI and data to consistently review and improve performance. Staff we spoke with told us there were many factors that affect deployment times, for example the weather, gathering additional specialist equipment, or completing additional risk assessments due to complex locations of emergency scenes.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients and relatives knew how to complain or raise concerns. The service had an up-to-date complaints policy and a dedicated section on its web site called the "Patient and relative hub." Patients and relatives could use this link to leave feedback, contact the service's team, and share their experiences, both good and bad. The staff could also leave calling cards at a scene with the details of the service in case anyone would wish to make a complaint.

Data supplied by the service following our inspection showed the service received no complaints in relation to its frontline clinical activities.

Outstanding ☆

Emergency and urgent care

Staff we spoke with understood the policy on complaints and knew how to handle them. All complaints within the service related to non-clinical operations, for example fund raising activities. We reviewed an example of a complaint received by the service, and how this was managed including the feedback to the complainant. Details in the complaints response showed that staff had followed the services complaints policy and provided a detailed response to the issue raised.

Managers investigated complaints and identified themes. Managers were clear in their roles regarding investigating complaints. The complaints were sent to the individual managers dependent on the nature of the complaint so they could be thoroughly investigated.

Staff we spoke with knew how to acknowledge complaints and received feedback from managers after the investigation into their complaint. All complaints were acknowledged in line with the service's complaints policy and a detailed response given to all complainants.

Staff could give examples of how they used patient feedback to improve daily practice. Staff we spoke with told us that it was very rare to get complaints from patients or relatives that had used the service. During our inspection we spoke with 7 patients and 1 relative, the described the service as outstanding, amazing, lifesaving and life changing. They had no complaints about the service and said the team had been professional and fully engaged with them at all times.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints could be shared with the staff teams through the service team reads and updates on its intranet and feedback from the clinical governance team. Front line staff told us they would reflect on any complaints to ensure that any changes needed as a result of a complaint were embedded and to ensure similar complaints were not repeated. Clinical governance processes embraced complaints and managers promoted an open culture of listening to, responding to and learning from complaints. The service's trustees had oversight of all complaints as part of the clinical governance reporting framework.

Are Emergency and urgent care well-led?

Outstanding ☆

We have not previously rated this service. We rated it as outstanding.

Leadership

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

The service had a comprehensive and experienced leadership team, with clearly defined roles and responsibilities at all levels. The chief executive officer (CEO) led the service, reported to a board of trustees and was the registered manager. All staff we spoke with told us the CEO was very visible, highly committed, approachable to all and always promoted the services mission and values.

The service's trustees had a wide range of professional backgrounds, in order to offer a broad set of skills and wide range of experience to the services leadership team. The trustees we spoke with were passionate and excited about the service and wanted to contribute their time to make a difference to saving lives within the community. They told us the leadership team kept them well informed of any incidents, or risks within the services, and that the team were focused on continually improvement and learning to develop the service.

Leaders had the skills and abilities to run the service. The CEO led a highly experienced and established team including the medical director, director of operations, business support manager and director of fundraising and marketing. The registered manager understood the importance of health care regulation within their day-to-day leadership roles and its importance in maintaining patient's safety, innovation and positive outcomes.

The medical director was highly valued by the staff team, and by external stakeholders. One external stakeholder told us the medical director had been instrumental in supporting the development and implementation of their clinical governance frameworks and had been pivotal in supporting their response to the COVID-19 pandemic and improving training in life support techniques and training.

During our inspection we observed inclusive and effective leadership at all levels. Leaders demonstrated high levels of experience, capacity and capability within hospital emergency medical services (HEMS) needed to deliver high quality and sustainable care. The service invested in the development of leadership roles across the service, including succession planning and to respond to increased demands within the service.

One of its strategic objectives was around workforce planning and ensuring that the service had skilled, committed and motivated people whose wellbeing and development were cared for and supported. Staff we spoke with told us that leaders were committed to ensuring they had the appropriate training and support to carry out their roles appropriately and provide opportunities to develop their skills and competencies.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a mission "To save lives and limit disability by taking enhanced emergency care to patients in their moment of need" and a vision to "Deliver the best pre-hospital emergency care to our patients."

The service had a 5year strategic plan and strategic objectives linked to achieving its mission and vision. The strategic objectives were regularly reviewed by the trustees and leadership team and involved wider stakeholder engagement in order to meet the service's overall vision and mission. The service had a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans which linked to staff development and the services staff appraisal and key performance indicators (KPI).

Staff we spoke with were aware of the services mission and vision, and the plans for the new location and managers had clear objectives and job roles designed to ensure the strategic plan was implemented and reviewed. This was overseen by the trustees and progress reviewed within the clinical governance structures.

Emergency and urgent care

The service's strategy and objectives were fully aligned with plans in the wider health economy, and the service demonstrated commitment to system-wide collaboration and leadership through its ongoing stakeholder engagement, and all staff were committed to provide integrated emergency services across the region.

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 we spoke with told us they felt respected, supported and valued by the leadership team and each other**.** Staff were committed and passionate about providing high quality pre-hospital emergency care to people and advancing their skills, knowledge and competencies. Staff told us they were exceptionally proud to work for the service and were positive about the work they undertook and the impact they had on peoples' lives.

The staff described themselves as feeling like part of a wider team focused on achieving positive outcomes for patients, but also supporting each other and being the best team and being the best at what they do. There was a genuine recognition that without respecting each other, and having the ability to challenge and stretch each other, patients wouldn't get the best care they could offer, so they worked within a culture of maturity and willingness to share and challenge ideas and practice.

Non-clinical staff understood how their roles positively affected patient care and all staff we spoke with felt valued at every level within the service. Managers and staff told us there was a culture of collective responsibility between all staff and managers.

Staff and volunteers we spoke with told us they felt part of a team and felt they worked well together and supported each other. Staff said that managers were always willing to listen to them and provide extra support when needed, they also said that the executive team and trustees were accessible and willing to help them wherever they could. They described how staff, patients, relatives, volunteers and trustees worked together to support the service and implement continuous improvement to meet the needs of the local population. Many of the volunteers had been directly affected by the service, and either they or their relatives had received lifesaving treatment from the service.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff described a deeply embedded culture of "Working together to saves lives." All the staff and volunteers we spoke with knew how their role and activities affected patient outcomes. Leaders promoted an open culture, which staff described as a "Just culture", to enable staff to celebrate from success and learn when things went wrong, for example incidents and complaints.

The service placed a strong emphasis on promoting the emotional and mental wellbeing of the staff. HEMS staff often faced traumatic scenes in their day-to-day work and we witnessed this during our inspection. Staff had the opportunity to debrief and discuss their experiences and leaders were caring and compassionate to their needs. The service took a proactive approach towards staff's mental and emotional wellbeing and provided an employee assistance programme, which was accessible to staff and their direct family.

In the service's staff survey 2022, 91% of staff said they believed the service acts with kindness respect and gives emotional support to staff when needed. The leadership team had developed several actions to make improvements in the service based on staff feedback, including increasing the frequency of staff meetings, improved its internal intranet system, and upgraded some areas of the estate and facilities.

Outstanding ☆

Emergency and urgent care

Staff told us that leaders were visible and approachable in the service for patients and staff. Staff we spoke with told us how they could always go to their managers, the senior management team, or trustees to discuss concerns or talk about the service. The service had a freedom to speak up guardian (FTSU) within its trustee team to enable staff to raise concerns impartially from the main staff or leadership.

As part of its commitment to equality, diversity and inclusion, the service was an accredited disability confident employer, and subscribed to the race at work charter and national living wage foundation. The service employed a number of serving and ex-armed forces personnel. The defence employer recognition scheme (ERS) encourages employers to support defence employees and the scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant. The service had signed the Armed Forces Covenant and was awarded a Silver Award in the 2022 Ministry of Defence Employer Recognition Scheme.

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.

Leaders operated effective governance processes, throughout the service and with stakeholders. Governance arrangements were proactively reviewed and reflected best practice in the urgent and emergency care sector. The service had a systematic approach to working with other organisations to improve patient outcomes and staff saw the opportunity of working with other organisations as key to improving services. There were clear lines of accountability for governance from trustees, through to the executive teams, and wider staff teams.

We spoke with 2 external stakeholders who told us that the service was proactive in its approach to governance when working in partnership. One stakeholder told us that due to the quality of the service's governance processes, they had made significant improvements and changes to the quality of their own service due to adopting best practice guidance and identifying and managing risks. One stakeholder told us that the service's medical director was inspirational, highly skilled and willing to work with them to make positive changes and improve urgent and emergency services for the wider community as part of its governance processes.

The service's clinical governance committee (CGC) met monthly and reported directly to the board of trustees. There was wide representation on the CGC from staff across the services including doctors, critical care paramedics and members of the executive leadership team. Clinical operations governance reports we reviewed demonstrated that the service had comprehensive processes for reviewing patient safety, the quality of clinical care, operational activity, risk and significant events. Staff told us how they attended and got feedback from death and disability meetings which were held monthly to discuss and encourage learning and innovation in response to any incidents within the service.

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. Trustees we spoke with told us the executive leadership team had clear oversight of risk and performance and supportively held managers to account to ensure risks were managed and updated in line with the services governance and risk processes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Emergency and urgent care

Leaders and teams used systems to comprehensively manage performance. The service used a range of key performance indicators (KPIs) to measure performance and identify where improvements were required and celebrate success. We looked at records, including governance meetings, KPI reports and team meetings that showed the service monitored and pursued progress against KPI and challenged any non-compliance.

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had a risk register that reflected the up-to-date risk profile for the service, for example risks such as long-term loss of aircraft, insufficient staffing levels for clinical services and solo paramedic responding. Risks were rated appropriately and had mitigations, time frames for review and named individuals responsible for updating and mitigating the risks. Staff we spoke with knew what was on the services risk register.

The service regularly reviewed how they responded to risks and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Staff completed training to carry out investigations, often with external agencies for example the civil aviation authority (CAA) and its air ambulance providers, to establish risks that had contributed to incidents and how to mitigate these in the future.

The service had plans to cope with unexpected events and had up to date and detailed business continuity plans and comprehensive processes for managing major incidents. Managers told us they reviewed their business continuity plans regularly and ran major incident scenarios to ensure the service was prepared for deployment. The service subscribed to the joint emergency services interoperability programme (JESIP) in order to respond in collaborative ways with other services during an emergency. Staff we spoke with fully understood their roles and responsibility in relation JESIP and had completed additional training to respond to major incidents.

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.

The service collected reliable data and analysed it. The service had a digital audit system that tracked all their audit information which included information about cleaning schedules, incidents, and response times. This system was used to monitor specific areas of risk as well as look for areas to improve the service. We found the information used to report KPI performance and delivering quality care was consistently accurate, valid, reliable, timely and relevant with key individuals given responsibility for ensuring this was the case.

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, including those for patient records and KPIs. The service had secure electronic systems with security safeguards including individual usernames and passwords for each member of staff. The physical security of the base was secure, only people with security access could enter the building out of office hours and all visitors' identities were carefully confirmed before allowing them entry to the location.

The service had up to date data and information sharing agreements in place with key stake holders in relation to HEMS, patient care, safety, quality and outcomes. Staff we spoke with across the teams were committed to sharing data and information proactively to drive and support internal decision making as well as system-wide working and

improvement of patient outcomes. External stakeholders we spoke with told us that the service shared key information relating to operational activity, patient safety and the quality of the service. They told us that leaders and staff were willing to engage with them in order to share information which would lead to improvements within the service and discuss learning identified when things went wrong.

Staff had training on how to keep information secure. We looked at records that showed all staff were given information governance training. The service had a Caldicott Guardian, who was a responsible for protecting the confidentiality of people's health and care information and to ensure it was used properly and the service had an up-to-date data and security policy.

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.

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. Engagement with patients and relatives to share their stories and gather feedback was a key part of the service's culture.

The service effectively involved members of the public. The service's website provided a large variety of information for the public including patient stories, material about their team, and the service's history. They also took part in television programmes that showed the wider public examples of critical lifesaving treatments provided by the air ambulance staff. Some of the patients we spoke with told us they had either been on television or shared their feedback for the services "Flying High" magazine.

The service had a range of volunteers and a dedicated fundraising team that arranged and managed a variety of events to engage with the public and raise funds for the charity. One volunteer we spoke with told us that following lifesaving treatment from the service, they had gone on to be a community first responder and provided cardiopulmonary resuscitation (CPR) training to the local community. During 2021-2022, the service provided CPR training to over 3,340 people within the local community as part of its strategic objective to offer clinical training.

The service effectively engaged with their local partners. The service held quarterly meetings with 2 local NHS ambulance services that they worked alongside and held a range of meetings with other stakeholders including other emergency services, aviation specialists in order to provide a service to meet local needs.

We reviewed records of team meetings held in June, July and August 2022. Areas included KPI feedback, appraisal updates, training, staff wellbeing and other general matters of importance related to the service. The service had effective systems in place to ensure staff who did not attend meetings had access to meeting records and opportunities to discuss any updates with their manager and other team members.

The service carried out staff surveys annually. The staff survey results from 2022 were reviewed by the senior leadership and trustee team who took several actions to address any areas where staff felt they required additional support or where they felt the service needed additional development.

Staff participated in the services wellbeing survey 2022, to establish if staff felt they had access to the right support and resources to support their ell being and mental health. The majority of staff said they felt able to access appropriate resources to support their wellbeing and mental health.

Emergency and urgent care

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff we spoke with were committed to continual learning and improving services in order to save lives and limit the impact of life changing events. Leaders encouraged the safe use of innovative and pioneering approaches to pre-hospital emergency care and how it was delivered to achieve the services mission and strategic objectives. The service proactively supported staff to take part in research as they felt this was key developing services for the future.

Managers and staff had a good understanding of quality improvement methods and the skills to use them. All the managers and staff we spoke with knew how the service collected key performance data, audit data and governance information to improve the services. During our inspection information we reviewed, for example governance records, staff meeting records and key performance dashboards demonstrated that staff used this information to consistently monitor and improve on the quality of the service.

Leaders consistently encouraged innovation and participation in research. All staff were genuinely passionate and committed to using recent research to improve the quality of patient care. Staff we spoke with were enthused to tell us about new research they had been or were currently involved in and how this would benefit patients. They gave numerous examples of research projects and how these had positively impacted on the service.

At the height of the COVID-19 pandemic the service was one of 3 urgent and emergency care services that worked with the national critical care transfer cell (NCCTC) and national ambulance resilience unit (NARU) to offer support for critical care transfers to patients who were COVID-19 positive. This work was an important contribution to the UKs critical care transfer capacity at a time of national emergency. The service's air ambulance teams carried out 23 successful out of region transfers and helped ensure that critical care units under the greatest pressure were supported when needed, and that the patients were able to receive the highest-quality care.

The service installed and used a bespoke decontamination pod, the system gave the service the ability to decontaminate medical equipment and personal protective equipment to the highest standards. The system utilised a dry system, with low concentration hydrogen peroxide as a very effective decontamination system. This system was effective against extremely difficult to kill pathogens, well over and above corona-virus type organisms as well as preparedness for further pandemics in the future.

The service was working in partnership with the paediatric and neonatal decision support and retrieval service (PaNDR) and offered senior doctors within the service a 50:50 split role working with the services HEMS team and with PaNDR. PaNDR provides critical care retrievals for children up to the age of 16 years requiring transfer from 15 hospitals across the East of England with 3 paediatric teams in operation 24 hours a day, 365 days a year. The teams are made up of consultants from paediatric intensive care units and paediatric anaesthesia, retrieval fellows, and experienced retrieval nurses supported by ambulance technicians. In addition to specialist retrieval, they also offer clinical advice to health professionals caring for all children, from extremely preterm infants up to 16-year-olds.

The service launched a solo paramedic shift into its staffing rotas in May 2022 and in its first 3 months, the paramedics covered 24 shifts, were activated to 40 incidents, and saw 24 patients. Solo paramedic shifts enable the service to offer

more patients with advanced care on occasions when shift may have been dropped due to a lack of 2 staff to provide the service. At the time of our inspection the service was further developing the advanced paramedic role and the development of the services advanced paramedic career pathway to enable the service to provide more patients with advanced care when they need it.

On 4th December 2018, ultrasound devices were introduced into the service. Previously point-of care ultrasound (POCUS) had not been an investigation performed by the services clinical staff team. In January 2021, the services carried out an audit to review clinical effectiveness and application of such investigations and implemented a number of recommendations to improve staff practice and patient outcomes.

The service was engaged with the police another urgent and emergency care and road safety organisations to deliver road safety across Cambridgeshire and Peterborough.

One of the services key strategic objectives was to increase public awareness of immediate life support and cardiopulmonary resuscitation (CPR) in the community. It was committed to delivering training to as wide a public audience as possible in order to meet the needs of local people who may need support from community first responders or the public during a cardiac event. During 2021-2022, the service provided CPR training to over 3,340 people within the local community as part of its strategic objective to offer clinical training.