East Anglian Air Ambulance

Helimed house

Inspection report

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Norwich
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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?	Outstanding ☆
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 to all staff and made sure everyone completed it.
- 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. Staff and managers worked together with external stakeholders to safeguard their patients.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.
- The design, maintenance and use of facilities, premises, vehicles and equipment was innovative and kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- People were protected by strong comprehensive safety systems, and a focus on openness, transparency and learning. A proactive approach to anticipating and managing risks to people who used services was recognised as being the responsibility of all staff. Staff identified and quickly acted upon patients at risk of deterioration. External organisations were actively engaged in assessing and managing anticipated future risks.
- 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 agency staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and stored securely. They had innovative ways to make patient information more easily available to all staff providing care.
- 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. New evidence-based techniques and technologies were used to support the delivery of high-quality care.
- 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.
- 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.
- All staff were actively engaged in activities to monitor and improve quality and 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 being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- 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.
- 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.

Summary of findings

- 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.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Staff provided emotional support to patients, families and bystanders to minimise their distress.
- 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. The service had developed innovative ways to improve the access people had 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 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. Managers 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 innovative approaches to gather 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. There were consistently high levels of constructive engagement with staff, patients, relatives and external stakeholders.
- 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 to all staff and made sure everyone completed it. • 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. Staff and managers worked together with external stakeholders to safeguard their patients. • The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean. • The design, maintenance and use of facilities, premises, vehicles and equipment was innovative and kept people safe. Staff were trained to use them. Staff managed clinical waste well. • People were protected by strong comprehensive safety systems, and a focus on openness, transparency and learning. A proactive approach to anticipating and managing risks to people who used services was recognised as being the responsibility of all staff. Staff identified and quickly acted upon patients at risk of deterioration. External organisations were actively engaged in assessing and managing anticipated future risks. • 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 agency staff a full induction. • Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and stored securely. They had innovative ways to make patient information more easily available to all staff providing care.

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- 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. New evidence-based techniques and technologies were used to support the delivery of high-quality care.
- 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.
- 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.
- All staff were actively engaged in activities to monitor and improve quality and 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 being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- 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.
- Staff supported patients to make informed decisions about their care and treatment. They

Summary of findings

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.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Staff provided emotional support to patients, families and bystanders to minimise their distress.
- 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. The service had developed innovative ways to improve the access people had 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 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.

Summary of findings

- There was a strong culture that was centred on the needs of patients. Managers 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 innovative approaches to gather 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. There were consistently high levels of constructive engagement with staff, patients, relatives and external stakeholders.
- 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

We rated this service as outstanding because it was safe, effective, caring, responsive, and well-led.

Summary of findings

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Background to Helimed house

Helimed house is operated by the East Anglian Air Ambulance (EAAA). EAAA is a registered charity that provides a helicopter emergency medical service (HEMS) and rapid response service 365 days a year from its air base in Norwich. In summer 2021, EAAA became the first HEMS service in the East of England to fly its air ambulances 24 hours a day, including night missions. 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 EAAA staff to deploy the most appropriate resource to emergencies.

The service covers the East Anglian region and between 1 June 2021 and 31 May 2022, the service was tasked to 2,549 missions and treated 1,812 patients, 126 (7%) were children aged below 16 years and 1,686 (93%) were adults. As part of the services strategic aim to offer 24 hours per day, seven days a week cover by its air ambulances and upgrade its existing facilities for the future, the service moved into its new headquarters in the spring of 2021. The environment had been designed and planned specifically to provide resources for the whole team. Design stages had involved stakeholders from across the East of England, including staff, volunteers, patients, relatives, engineers, funders and a designated culture group with representatives from across the service to discuss and design the new facilities. The result was a new build that was open and light with user-friendly spaces to encourage interaction between people, whilst maintaining safety and confidentiality.

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 21 June 2022, at its location in Norwich. We spoke with staff, volunteers, five patients and two relatives, reviewed 15 patient records including medicines and documents in relation to the safe operation of the service, for example policies and procedures.

We last inspected the service on the 5 February 2018 and did not rate the service. At this inspection we have rated the service as outstanding for safe, effective, caring, responsive and well-led, and outstanding overall.

How we carried out this inspection

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

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:

- The service promoted an open, “Just” culture to reporting all types of incidents. Patients benefited from a culture of learning that responded when things went wrong to provide innovative care and treatment.

Summary of this inspection

- Governance systems ensured incidents were comprehensively reviewed and used to inform scenario simulation-based training. All staff were involved with the investigation of incidents in order to make improvements.
- The service had conducted research on new methods of treatment and care, new technology, new procedures and were continuing to challenge the limits and risks of what treatments were safe and possible for patients.
- The service engaged with a wide range of partners with the aim of improving its services and the quality of care for all patients. This included working with; local NHS trusts training their staff, armed forces, air ambulance services across the region and internationally sharing learning an innovation.
- The service had strong inspirational leadership that consistently supported people across the service and created a positive patient focused culture. Learning, research and innovation was encouraged at all levels in order to improve patient outcomes, promote patient safety and achieve the services mission of saving lives 24 hours a day, seven days a week.

There were many more examples of outstanding practice not included in this report. 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	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding

Emergency and urgent care

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

Are Emergency and urgent care safe?

Outstanding

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

Mandatory training

The service provided comprehensive mandatory training in key skills including the highest level of life support training to all clinical staff and made sure everyone completed it.

The service had comprehensive systems to ensure staff received and kept up to date with their 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 patients benefited from the range of life saving training and interventions provided by staff in an emergency.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, and dementia. At the time of our inspection all staff had achieved 100% compliance with mandatory training and gave examples of how they used this training to provide care and treatment to patients. Clinical staff used an online application on their mobile phones which showed their training status, green for fully complaint and red for requiring updates. Staff would use this application at each shift handover and check and challenge that their colleagues to ensure their 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. The service leadership team included a deputy medical director role to support clinical education and research. 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. Staff could not work on front line shifts in emergency settings unless they had completed all the mandatory training elements.

Managers and human resource staff worked as a team to ensure training was a priority and staff could manage their own training needs direct from the IT training systems. As part of the redevelopment of the location the service provided a wide range of spaces where staff could learn, carry out reflective practice or do live training scenarios in the services “Immersive Training Suite”. The service had also worked with the manufacturers of emergency equipment and had developed bespoke training equipment to replicate those used by staff on missions.

If staff were not on missions and they had completed checks on equipment and admin roles were complete, the clinical staff would then 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 that included medical mannequins that represented people from ethnic minorities, to promote diversity and inclusion within their practice.

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 with clearly defined roles and responsibilities for staff regarding safeguarding and the safeguarding referral process.

Staff received training specific for their role on how to recognise and report abuse. All clinical staff had completed level two and three 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 had completed safeguarding training and received updates at appropriate levels and in line with their roles and responsibilities. The registered manager had completed safeguarding training at level three for adults and children. The service had dedicated and appropriately trained safeguarding leads with links to local safeguarding networks to gather additional updates on safeguarding practice. The safeguarding leads sat on local safeguarding boards and had completed additional safeguarding training to provide comprehensive systems to keep people safe, which considered current best practice.

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.

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. Patient records had dedicated areas for staff to record safeguarding references numbers and safeguarding details. The safeguarding leads had access to this information so they could follow up on all safeguarding referrals made and establish the outcome of the referral and share any learning with the staff teams.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with had a comprehensive understanding of safeguarding processes, and how to recognise and report the characteristics of abuse. The staff gave examples of when they had been called to domestic violence situations, self-harm and stabbing incidents which required a multiagency safeguarding approach on scene.

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 clean and had suitable furnishings which were clean and well-maintained. The service moved to its new headquarters in the spring of 2021, and all the fixtures and fittings within the location were new, with no signs of any deterioration.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We looked at one helicopter and two 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 managers and the clinical governance committee to ensure compliance with the required standards had been met.

The service performed well for cleanliness. We looked at cleaning logs of the services base and vehicles, staff had fully completed these and the location was visibly clean when we visited. Records showed that between January and June 2022, the service routinely performed above its 90% IPC compliance rate in all areas of the base and its vehicles for hygiene and infection, IPC checks.

Staff followed IPC procedures including the use of personal protective equipment (PPE). Staff we spoke with had a comprehensive knowledge of the services IPC processes. The services 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. 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 or care. This was in line with *NICE guideline QS61 Statement 3 (2014), Infection prevention and control - Hand decontamination.*

The service had a deep clean programme for the rapid response vehicles once a month which was carried out by the staff team. The air ambulances were 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 prior to 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 and we noted all vehicles had supplies of antibacterial wipes on board.

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 which contained a washing machine, and a “dump shower” to allow staff who may be contaminated to remove a contaminated uniform. A dump shower helps remove heavy contamination from staff and avoids spreading any bacteria or infectious material through the base. The sluice room had appropriate cleaning equipment and guidance for staff in relation to *Guidance on the Control of Substances Hazardous to Health Regulations 2002.*

Sterile consumables were stored correctly and safely. We checked ten 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. As part of the services strategic aim to offer 24 hours a day, seven days a week cover by its air ambulances and upgrade its existing facilities for the future, the service moved into its new headquarters in the spring of 2021. The environment had been designed and planned specifically to provide resources for the whole team. Design stages had involved stakeholders from across the East of England, including staff, volunteers, patients, relatives, engineers, funders and a designated culture group with representatives from across the service to discuss and design the new facilities. The result was a new build with open and light user-friendly spaces to encourage interaction between people, whilst maintaining safety and confidentiality.

Emergency and urgent care

Front line staff now had sleeping quarters that had been specifically designed to promote their wellbeing and increase their comfort when covering night duties. Staff slept in one of six pods, with privacy screens, lighting and access to Wi-Fi to enable them to relax between missions on night duties. The service had also developed a separate suite of sleeping quarters for staff who may need to stay at the location, for example due to a long journey after shift. These were spacious bedrooms, with private ensuite facilities. The service had several kitchens for staff to use, which were open, light and spacious and had a wide range of equipment to enable them to prepare meals or just sit for a break with colleagues.

The service had an “Immersive Training Suite” which used technology to project simulated images onto the three walls, for example a busy moving motorway, and created the illusion of being stood on the moving carriage way. A dedicated control room enabled staff to change training scenarios, and environments, lighting temperatures and weather conditions, to simulate those staff were likely to face when on missions. The three walls were touch sensitive and the service had worked with equipment manufacturers to provide training resources, so the equipment used in simulations matched those on missions.

The service trained staff on the use of all equipment. Staff told us before a new item of equipment was used with patients the managers put the piece of equipment out for staff to get familiar with it. They would also have a user manual for the device. Staff reported that this was essential for them to learn every detail of a new piece of equipment including how to charge the device, how to test it and how to identify common problems with it. Managers told us if staff were still unsure, they provided additional training and daily training on equipment was commonplace to keep staff current in its use. The service also used working parties consisting of staff from across the service to review equipment, both old and new, to ensure they have the most up to date equipment within the service that met patients’ needs.

Staff carried out daily safety checks of specialist equipment in order to keep people safe. The service kept an electronic record of all equipment checks carried out by staff, records we reviewed showed that checks were completed, and records were scrutinised by managers and the services clinical governance committee. Staff completed a daily loading list to ensure all necessary equipment was in the vehicle. The daily loading list for May 2022, showed staff achieved 97% compliance in the day and 94% compliance at night, both were above the 90% compliance target set by the service. 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 had 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, and keys were stored safely inside the base. The service carried blood as part of its emergency care response. As part of the building design process, the service had worked with the local blood suppliers to develop as systems where blood could be safely dropped off by the couriers, without entering the building using double hatch system, protected by unique key codes which reduced the need for the couriers to enter the location. Blood boxes contained a data logger that showed the box was at the right temperature and alerted staff if the blood fell out of the correct temperature ranges. This new system meant that the service had not wasted any blood products, helping to safeguard blood supplies across the health system.

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. The night vision goggles were a technically advanced piece of equipment and before each use, the staff used a device that allows the goggles to be calibrated for each user.

Staff disposed of clinical waste safely. Staff followed the services IPC policy in relation to clinical waste, we noted that staff stored clinical waste safely, including sharps and the service had an up to date 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 which led them to improve and implement their own guidance around patient risk. The service had developed 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 stroke, cardiac arrest, major haemorrhage, or head injury, amongst others, all based on best current practice models. The service had an up to date *standard operating procedure 5.12, triage, disposal and transport*, to guide staff in ensuring patients were taken to the nearest facility offering damage control or definitive care for their condition.

The service managed risks proactively and positively. Two clinicians routinely performed a 'check and challenge' risk assessment. One challenged the other by asking if equipment was prepared or present and the other checked that it was. 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 during intervals. The service had a process which allowed a consultant either on call or at the location to provide clinical advice by telephone and give guidance on the patient's condition. Staff used this process to get additional clinical advice when on scene and during patient transit. Staff told us the support by consultants 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 request through the NHS ambulance critical care desk. The critical care desk could call in support from other services. In most circumstances, the helicopter emergency medical service (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. The service responded to patients with serious injuries and significant blood loss who would have to wait until reaching hospital to receive blood products. The service had standard operating procedures for major blood loss and the risks this posed to patients. The service had a service level agreement with a local NHS trust to enable the team to transport blood products and give these to patients on scene. Blood products themselves can pose a high risk to patients and the service audited their compliance with the process of handling of blood products.

Staff 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 the change to night flying, the teams had introduced 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 the Immersive Training Suite to simulate missions at night and highlight the additional risks associated with working in limited light. Any learning from the simulations was shared with the wider teams. Staff openly discussed and challenged each other to anticipate and manage risks to people who use services 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 and adjusted 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, seven days a week, this consisted of two pilots, a critical care paramedic (CCP) and a doctor or consultant on duty.

The service employed all its clinical staff and most of its CCP's. However, some CCP's were employed by another NHS emergency service and worked for the service under agreement. 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. All staff received a comprehensive induction that covered a wide range of the services training and key details in relation to the service. The service employed eight staff within its consultant body including the medical and deputy medical directors, 17 emeritus doctors, five senior clinical fellows, three PHEM trainees, 77 ground staff, and 22 CCPs (these were seconded from the NHS and a mixture of full and part time).

Managers ensured there were always enough staff available to deliver the service. 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. The service audited its staffing provision and routinely achieved 99% compliance against the required staffing standards. Over the 12 months before our inspection the service had low sickness rates below 2.5%, vacancy rates were routinely below 3.5% and turnover rates were routinely below 2%. Records we reviewed with the services human resources 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 competencies to ensure managers could deploy competent trained staff onto the duty rota.

As the service was a registered charity, it had over 200 volunteers that helped the service with fundraising and various other roles. Volunteers we spoke with during our inspection had a unique reason for working or volunteering for the provider, these included wanting to make a difference, using their skills to help the service, or they had directly benefited from the care provided by the service, either as a patient or a relative.

The service had a dedicated aftercare team, staffed by qualified nurses. This meant due to their clinical knowledge they could work with patients and relatives post trauma, to discuss what happened, what treatment was provided and why.

Air ambulance pilots 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 were extremely positive and that they worked closely together to maintain pilot coverage.

The service had low rates of agency staff, between June 2021 and June 2022, the service used 2.9% agency staff to provide support the staff teams. Managers limited their use of agency staff and made sure all agency staff had a full induction and understood the service.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed 15 patient records that demonstrated staff had completed them clearly with medicines and interventions clearly recorded. Patient records were completed on scene in writing, then transferred to an electronic system, which was accessible across a range of devices back at the services location. Each time a patient record was completed, this was immediately reviewed by the consultant of the day or on call consultant as part of the service's clinical governance processes. This enabled staff 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 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. Appropriate staff from across the organisation, including the patient aftercare team, could log onto the records and review the details of patient care and treatment. This meant the aftercare team were able to work with patients and relatives post trauma, to discuss what happened, what treatment was provided and why. 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

Patients we spoke with said this opportunity had significantly contributed to their coming to terms with what happened, as they often had no recollection of any care or treatment provided due to the nature of their injury.

When patients transferred to a new team, there were no delays in staff accessing their records. Arrangements for recording decisions were clear, transfer locations were clearly noted in the patient clinical record. The receiving hospital were either provided with a paper record of the staff notes or an electronic copy depending on the facilities of the receiving hospital.

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 shouldn't be taken by a healthcare professional, including not performing cardiopulmonary resuscitation (CPR) on the person.

Outstanding ☆

Emergency and urgent care

Medicines

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

Staff followed systems and processes when safely prescribing, administering and recording medicines. The service used an electronic system to record details of missions. We looked at four records and saw that medicines had been prescribed, administered and recorded in line with provider policies and national guidance. The service also had good processes to communicate information to the receiving hospital about medicines they had administered to patients during the mission. This meant that the hospital team could continue treatment appropriately.

Medicines were stored safely and securely. Medicines and controlled drugs (medicines requiring more control because of their potential for abuse) were stored safely and securely. The controlled drugs cabinet would alarm in the hanger when opened which would alert staff to unauthorised access as well as there being 24-hour CCTV in operation. Two other sets of grab bags were kept in the boot of the active rapid response vehicle that was locked and inside an airlock and the air ambulance which was on the helipad outside the aircraft hangar.

The service ensured that medicines were stored at the correct temperatures in the storeroom. Each cabinet had a datalogger which had a small green flashing light if there had been no temperature excursions. This would change to red if there was a temperature excursion. The data logger recorded continuously and could be used to pinpoint the exact time a medicine was outside the recommended range. Medicines in air ambulance, unless refrigerated meds, do not necessarily need to be monitored. The service was conducting some tests to monitor temperatures of their medicines when in the air ambulance to ensure these continued to be suitable for use.

The service continually reviewed their processes when they had identified potential medicines risks. For example, we saw that the service had recently changed medicines in similar looking vials or containers to reduce the risk of selecting the wrong medicines when working at night or challenging environments. There was a robust and detailed clinical auditing system in place. After each mission a consultant on call would review the mission logs and debrief the clinical staff. Reviewing records to ensure they are completed properly and peer reviewing clinical decisions made to ensure that best practice was followed. The service gathered date from each mission onto a 'PowerApps' digital governance platform and would use data from this to track patient interventions and outcomes.

The service regularly published clinical papers about advanced critical care practice and some of these innovations had led to changes outside of the organisation, as other ambulance services had adopted their practice. One such example was the use of an inhaled form of pain relief for orthopaedic manipulation and fracture reduction which was trailed to be used rather than Ketamine which would require continuous doctor monitoring after its use. This enabled the air ambulance to staff to leave a patient with the regular ambulance service and attend other calls after administration if needed. Since the report was written the ambulance services in the area have begun to carry this medicine in their kit bags.

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.

Emergency and urgent care

Staff 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 phones while out of the office at scenes.

Staff reported serious incidents clearly and in line with the service policy. We reviewed five incident reports on site during our inspection which showed staff raised concerns and reported incidents and near misses in line with the services incident reporting policy. In the 12 months before our inspection the service reported 178 incidents. Most incidents related to medical equipment and devices 64, medicines 22, estates and facilities 14 and aviation seven. Staff told us that they received feedback from reporting incidents, for example where a medical device may have been faulty, and that the service was quick to respond to incident reports in order to make changes or replace equipment.

Staff told us that they worked within and were supported by an "Incident learning culture" not an incident reporting culture. Due to the nature of the incident reporting process and a culture where incident reporting was positively encouraging by the service. The provider had a sustained track record of safety and used accurate performance information to consistently improve its services and make progress towards safety goals reflected in a zero-harm culture. Staff told us this was influenced by the training and learning they received from the aviation teams, who promoted a no blame and "just culture" in relation to incidents.

The service's medical director reviewed all clinical risks, 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 investigate incidents where they had been involved. Staff who investigated incidents had been trained to carry out investigations. Bespoke route cause analysis training had been provided from aviation experts to enable staff to fully review and understand incidents and their impact on patients to ensure similar incidents were minimised in the future. The medical detector had received training and had significant experience in relation to route cause analyse and carrying out investigations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff we spoke to fully understood the role of duty of candour in relation to incidents and knew the service had an up-to-date policy in place. We were given an example of a patient who had an adverse reaction to medicine provided on scene, the staff spoke with the patient, explained the adverse reaction, the reasons why this may have happened and how they would use the feedback from the incident to share learning with the staff team.

Staff received feedback from investigation of incidents, both internal and external to the service. There was effective clinical governance process in place that reviewed all incidents and shared learning with the staff. Learning could be shared immediately by the services intranet system, which automatically recoded when staff had read updates on the system. Data in relation to staff accepting updates was audited to ensure all staff received updates and learning from incidents to improve safety.

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 in the Immersive Training Suite, 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 not only staff but patients, relatives and people who may have witnessed incidents, for example the public on scene.

Outstanding ☆

Emergency and urgent care

Are Emergency and urgent care effective?

Outstanding ☆

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

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies 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. We reviewed 14 of the service's standard operating procedures, 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 not only meet good practice standards in relation to national guidance, but to contribute to research and development of national guidance and shared this with other PHEM services across the region.

The service was assured new and existing staff had read and understood policies and procedures. 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 the service tracked who had or had not read a policy or an update. Data on staff compliance with updates was collated by managers and scrutinised by the services clinical governance committee to ensure all staff were aware of and using up to date guidance.

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 immediately reviewed by the consultant of the day or on consultant on call to ensure staff provided care and treatment based on current national guidance and evidence-based practice.

The service was consistently monitoring risk and using research to provide innovative care and treatment to patients. They were using their immersive training suite to practice scenarios, using equipment, technology and techniques to provide patients with lifesaving treatment in the most challenging environments.

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 one to ten; one being very little pain and ten being the worst pain possible. However, they also told us most patients were unable to communicate their pain due to being seriously injured. Staff showed us they had small note pads that patients who were awake but unable to speak could use to communicate in writing.

Staff would look at 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, intra nasal, inhaled or intravenous medicines dependent on the level and nature of the pain. All vehicles carried a trauma teddy, a teddy bear knitted by the series volunteers which staff gave to young children to console them and ask children to point to the teddy bear to show where the pain was. Staff used the one to ten scale for older children, or their notebook to draw smiley or sad faces or ask the children to write down or point to where their pain was.

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 which ensured patients were as comfortable as possible.

Patients received pain relief soon after it was identified they needed it or if they requested. Suitably qualified staff prescribed, administered and recorded pain relief accurately. We reviewed 15 patient records, six 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 flight to a hospital.

Patient outcomes

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

The service participated in relevant national clinical audits. Staff we spoke with were proud to participate in audit, and viewed this 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 information (KPI) that included patient outcome data.

The service had a research, audit, innovation and development (RAID) strategy (2020 – 2025), that was linked to its mission statement, "Together with our donors, we will push the boundaries in pre-hospital emergency medical care to measurably improve patient outcomes across East Anglia." At the time of our inspection the service was proactively engaged in 17 research projects and had published a research paper in April 2022. Audits and clinical research included, amongst others, survival rates for cardiac arrest patients, advanced airway management, the role of pre-hospital ultrasound and dispatch / activation criteria for pre-hospital critical care services.

The service was at the leading edge of innovation and technology to provide lifesaving interventions and promoting patient outcomes for example the use of specialist percutaneous emergency aortic resuscitation (SPEAR). SPEAR involves staff using ultrasound guided venous and arterial access for peri-arrest monitoring and drug administration. Staff within the service had extensive experience of providing pre-hospital invasive arterial monitoring using a dedicated over-the-needle arterial cannula with flow switch blood control. Clinicians used this device to monitor arterial pressures in ongoing resuscitation from cardiac arrest as it provided the following benefits: continuous blood pressure (BP) monitoring, easier recognition of return of spontaneous circulation (ROSC), and access for arterial blood gas sampling (ABG). Staff were trained 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 as part of its SPEAR programme.

Emergency and urgent care

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 to make improvements in the service.

Managers and staff used the results to improve patient outcomes. The patient outcome group reviewed patient outcome data and provided guidance to the services research and audit group regarding up to date and relevant research and audit.

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, KPI from audit was routinely reviewed by the services trustees and we reviewed a high level KPI report from April 2022, which showed trustees challenged audit outcomes and supported managers to make improvements by providing appropriate resources.

Managers used information from audits to improve care and treatment. The service was completing a comparison of deliberate self-harm incidents attended by HEMS before and during the COVID-19 pandemic in the East of England. The service was completing an audit of all patients who had undergone airway intervention in last five years and developing a monitoring dashboard to improve performance.

Managers shared and made sure staff understood information from the audits. Audit outcomes were a key part of feedback in the services governance processes. Governance records we reviewed demonstrated that information and performance from audit was routinely reviewed by the services extended leadership teams, executive team and trustees and shared with the wider staff teams.

Competent Staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work. The service's recruitment policy clearly set out roles and responsibilities for ensuring staff and volunteers had been inducted to the service and had the right information and recruitment checks completed to carry out their roles safely.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection all staff had received an appraisal. The appraisal systems was linked to training and development. If staff were not compliant in any areas of training, they would not be able to complete their appraisal, and would be held back from their front-line duties until they had completed all the necessary updates. Staff we spoke with said this was very rarely the case, as they did a routine check and challenge amongst each other daily and would identify any areas of training required before their appraisal. Managers also had access to live data on training compliance through the service's IT systems. Staff we spoke with said that managers were focused on ensuring training and competencies were always up to date.

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 an opportunity to discuss additional training. Managers made sure staff received any specialist training for their role including any specialist training in relation to their role or research outcomes in pre-hospital emergency medicine.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. Nursing staff were provided with appropriate supervision both one to one and group sessions.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff could access team meeting records by the service intranet. During the pandemic these had been on an IT platform, but face-to-face staff meetings were now taking place. Staff could access a wide range of meeting records and drop into clinical updates and training sessions as they became available. Staff could also request additional training, for example to practice a scenario in the immersive training suite and update their competencies on a piece of equipment or practice a specific emergency procedure.

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 thorough analysis and investigation of things that went wrong, for example incidents. All staff were encouraged to participate in learning to improve safety as much as possible, including working with others in the system and where relevant, 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.

The service's medical director was its responsible officer (RO). The RO is a senior clinician who ensures that the doctors for whom they act in this nominated capacity, continue to practice safely and are properly supported and managed in maintaining their professional standards and general medical council (GMC) registration and manage any allegations against medical staff.

The service ensured any staff required to drive the rapid response vehicles under blue light situations were appropriately trained. Managers maintained a central record of staff blue light training which we reviewed during inspection. This showed staff had met the required standards, and when their blue light driving update was required.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. Staff described a truly holistic multiapproach to assessing, planning and delivering care and treatment to all people who used services. Staff proactively worked together to identify and minimise risks to patients and they had used research and innovation as a team to improve patient outcomes.

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, ambulance staff, hospital staff and after care services. Staff described positive working relationships with other MDT staff in order to benefit patient outcomes and support the services mission of saving lives 24 hours a day, seven days a week.

Staff worked together and agreed plans to transport the patient. Before transporting the patient, the staff communicated with the other teams to discuss the best method of extraction. The teams assigned roles and tasked clinicians to retrieve appropriate equipment. 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 service also used their immersive training suite to help train staff from other services. Staff from other emergency services were invited to take part in training days. Managers told us of one example where these staff practiced assisting in transferring the patient onto the aircraft and working in darkness to manage unanticipated risks.

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

Seven Day Services

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

The service operated 24 hours a day, 365 days a year and its air ambulance became the first in the East of England to fly 24 hours a day from June 2021.

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. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with 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 procedure to guide their activities on scene.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. All 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. All clinical staff had completed training on the Mental Capacity Act and dementia, as well as safeguarding to ensure they understood the needs of people who may become more vulnerable to the nature of the emergency they were in.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. 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 interpreter services where necessary. Often staff could rely on relatives at a scene for additional support and information regarding the patient's condition, to establish whether the patient was living with dementia or other mental health conditions prior to treatment taking place. Staff understood 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 where patients could, they consented to treatment based on all the information available and records we reviewed showed staff clearly recorded patient consent in the patients' records. Managers reviewed and monitored practices and records around consent to improve how people were involved in making decisions about their care and treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 2007, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could describe and knew how to access policies and get accurate advice on the Mental Capacity Act. Staff showed us they had access to all policies and guidance on their work phones by an online IT system that staff could access these on scene. Staff could also contact the consultant on call for additional advice on any areas of capacity or consent whilst on missions.

Staff protected the rights of patients subject to the Mental Health Act 2007 and followed the Code of Practice. All the staff we spoke with explained the importance of protecting the rights of people who may lack capacity or be in a mental health crisis. Staff knew how to apply common law and ensure any medical intervention would be undertaken if considered to be in the best interest of the patient.

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.

Staff were discreet and responsive when caring for patients. During our inspection when speaking with staff, volunteers, patients and relatives we observed 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. Staff told us they often needed to remove or cut a patient's clothing off to fully assess their injuries but that they would where possible do this in stages and cover the exposed part of the patient with a blanket and if not possible then after removing all their clothes and undertaking their assessment they would cover the patient up immediately." Staff demonstrated that people's 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 and with kindness. During our inspection we spoke with five patients and two relatives. Feedback from people who used the service and those who were close to them were continually positive

about the way staff treated and supported them. They told us that staff had gone the extra mile and their care and support exceeded their expectations. Often due to the nature of patient injuries and the scene they could not remember the treatment provided by staff, but all patients and relatives we spoke with told us the patient after care team had been instrumental in their recovery process.

We reviewed a selection of recent patient feedback, one relatives feedback said, “Thanks to your wonderful team, the two paramedics that attended. We cannot thank you all enough! You are true heroes.” One patient’s feedback said, “It’s amazing what you all do and what a great team you are. Thank you once again. It’s definitely something we will never forget.” Another patient said, “You were absolutely wonderful” another said, “The work you do is amazing, and it is so good that there are real life heroes like you out there.” We noted feedback from bystanders to the service which said, “I just wanted to also say how good it was to speak with you,I really didn’t know where to start but speaking with someone who knew what had gone on and was there to listen and support was just amazing.” Another patient said, “Thank you for saving my life, thank you for giving me more time with my wife, children, grandchildren and friends, thank you for being so professional, thank you for making me feel fully reassured and safe.” One relative feedback said, “All of your staff were incredibly calm and professional throughout, ensuring that the patient remained calm. Without doubt, their swift actions assisted in ensuring that the patient received the best care possible and the outcome, thankfully, wasn’t more serious.”

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with a mental health condition. One relative told us that they had been on scene and fully involved in the incident involving their loved one. They told us that staff had been respectful and compassionate, taking their time to explain what was happening and why, and providing them extra time to come to terms with what was happening in a calm and respectful way. Another relative told us that the incident had been extremely traumatic, due to the nature of the emergency the staff had been extremely sympathetic, not only providing care to the patient but also to a close relative who had additional care needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff we spoke with knew the importance of interacting with patients and respecting their wishes. The service had clear processes for promoting equality, diversity and inclusion and the aftercare teams carried out equality monitoring for all patients and reported data to the trustees and managers to ensure they we are giving a good service to all members of the community and not marginalising anyone or restricting access to the service.

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 that the aftercare process and the teams involved were outstanding, describing staff as “superheroes” and “amazing”. They told us that the staff were highly motivated and inspired to offer care that was kind, respected their preferences and needs. The aftercare team helped patients and relatives to develop relationships between people who use the service, those close to them and staff that were strong, caring, respectful and supportive. Often patients and relatives became volunteers and advocates for the service based on the experience of care and wanting 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 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. When treating a child, staff told us they involved the parents as much as possible and considered their needs as well. All vehicles carried a trauma teddy, a teddy bear knitted by the

service's volunteers which staff gave to young children to console them during the emergency. 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. During recovery the services after care team had engaged with the family, and the child had visited staff who provided their care and went on to open the new location on opening day and celebrate the success of the service.

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 staff that had provided them with care on the day of their injuries as part of their recovery. They told us this had helped them fill in the gaps in their memory of the events of the day. One patient told us that meeting the team helped them to fully understand what had happened, as they were struggling to understand the events they went through. All the services after care team were qualified registered nurses, so were able to interpret clinical feedback and review patient records to give clarity about the care and treatment provided to the patient.

The service welcomed patients and their relatives to become volunteers and participate in patient groups 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 were hoping to be on a television programme dedicated to showing the impact of the air ambulance services, so they could share their experience of life saving care.

Throughout our inspection there was observed an overwhelming abundance of positive patient and relative feedback. The aftercare team were pivotal in coordinating the after-care service, with the full engagement of the services wider team. Staff recognised the importance of people having access to, and links with, advocacy and support networks in the community and they support people to do this. The service had developed its own patient per support group, where patients and relatives could speak openly about their experiences, seek feedback from others in similar situations and signpost each other to additional services, for example local cardio support networks, and bereavement services. Bystanders often contacted the service to get feedback, for example, to ask if the patient was ok. The aftercare team knew the principles around information sharing and respected the general data protection regulation (GDPR) in terms of providing feedback to bystanders. However, they did liaise with patients and relatives and where appropriate bystanders could be involved in the aftercare process. Often bystanders also needed emotional support due to the trauma they witnessed, and the aftercare team signposted them to the appropriate support services.

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 patient we spoke with said, "I couldn't believe what was happening, I thought my husband was dead, the paramedic was amazing, they gave me reassurance and explained everything that was happening", "I am sure my husband only survived due to the actions of the paramedic and the way they manged my husband's care." Another relative told us, "They told me exactly what was happening, the staff were amazing given the situation, they fully explained the situation and we felt listened to." Another patient said, "It wasn't until I spoke with the aftercare team at the hospital that I knew what had happened to me, if it wasn't for them contacting me and giving me time to explain what happened to me, I still don't think I would know or understand how I survived."

Outstanding ☆

Emergency and urgent care

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 to them. If patients were conscious, staff did have small note pads they could use to write details on, draw pictures to explain or ask patients to write details down if they were able.

One patient's feedback said, "My wife tells me the attention I received from the air ambulance was nothing short of incredible. I feel totally humbled by the commitment, support, professionalism and human kindness given to be by the superb team that helped me and my wife on that day, words are not enough." Another relative feedback said, "I would like to say how fantastic all the paramedics were, and the air ambulance staff. They treated my husband with a huge amount of care and respect, explained the whole time what they were doing, despite him being unconscious. The staff kept reassuring me and promised to call me from the hospital, and they did. Truly amazing."

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients, relatives and bystanders could give feedback on the service and their treatment and staff supported them to do this. Staff told us they gave out business cards on scene to patients, relatives or bystanders that contained the service contact details and explained how they could contact the service for advice and support.

The hospital emergency medical service records system enabled the services aftercare team to follow up with patients and their relatives, where appropriate. The aftercare team showed us several examples where they had contacted patients and relatives to engage them in the aftercare process. The aftercare team were sensitive to the situation, as the incidents often led to life changing injuries, significant changes in the patient's life, and bereavements. Patients had opportunity to visit the location and meet the staff involved in their care, including clinical staff, pilots and managers, amongst others. Patients and relatives we spoke with told us this was really important to them and they had the opportunity to ask additional questions and say thank you in person to the people who had saved their lives and truly understand what had happened to them.

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 unbale 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 developed its staffing levels, the type of aircraft and rapid response vehicle it used in response to the number and type of pre-hospital medical emergencies that happened across the East of England Region.

Emergency and urgent care

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. It did this based on research from the Trauma and Audit Research Network (TARN) to consider the type of pre-hospital emergency clinical interventions used, for example the prevalence of road traffic collisions, and cardiac patients so they could deploy the most effective resources to the scene.

The service had recently become the first air ambulance in the UK to upgrade its air ambulance with a new five blade rotor head. This generated more lift, reduced vibrations and improved handling and stability, providing improved comfort for patients and staff during missions.

Facilities and premises were appropriate for the services being delivered. As part of the services strategic aim to offer 24 hours a day, seven day a week cover by its air ambulances and to upgrade its existing facilities for the future, the service moved into its new headquarters in the spring of 2021. The environment had been designed and planned specifically to provide resources for the whole team. Design stages had involved stakeholders from across the East of England, including staff, volunteers, patients, engineers, funders and a designated culture group with representatives from across the service to discuss and design the new facilities. The result was a new build with open light and user-friendly spaces to encourage interaction between people, whilst maintaining safety and confidentiality.

The service had suitable facilities to meet the needs of patients' families. The increase in office space meant the service had been able to relocate its fundraising, volunteers, and management teams into one location. We observed the teams working in open spaces, which promoted a culture of team working and positive interactions amongst the staff and volunteers. There was an abundance of office spaces, open spaces for group discussions, training, or private areas for confidential discussions or to meet with patients or relatives. The team benefited from a breadth of wellbeing facilities, including an inhouse gym, with private showers, lockers and gym equipment. The Community Hub was used for a wide range of internal and external events including delivering lifesaving training to the local community and fundraising events. We observed positive messages displayed throughout the environment on notice boards, a living wall and living desks spaces with grass and plants to provide mindful spaces for people to interact and promote a positive environment for people to work and learn in.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. 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 translation at the scene. Interpretation services were available for staff in the treatment of patients whose first language was not English.

The service supported patients that were unable to communicate verbally. Staff showed us small notepads that they used to allow patient to communicate in writing. All vehicles carried a trauma teddy, a teddy bear knitted by the series volunteers which staff gave to young children to console them and ask children to point to the teddy bear to show where the pain was.

Wheelchair users had access to services on an equal basis to others. Due to the severity of illnesses and injuries attended, staff carried most patients to the aircraft, or an ambulance provided by the local NHS trust. The location was fully wheelchair accessible for any visitors to the service, with lifts and call alarms in all toilet areas.

The service had invested in a range of training resources that included medical mannequins that represented people from ethnic minorities, to promote diversity and inclusion within their practice. And all staff were compliant with equality, diversity and inclusion training.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored response times and made sure patients could access emergency services when needed and received 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 phone line. People phoned 999 and talked with the NHS ambulance service critical care team who would liaise with the air ambulance teams to dispatch the most appropriate resources to scene. The service operated its air ambulances seven days a week 365 days a year, supported by rapid response vehicle (RRV) dependent on staffing levels and weather conditions.

By providing the air ambulances service 24 hours a day, seven days a week the service estimated it could be tasked by air ambulance up to 600 more times a year, delivering critical care to those in need faster at night and closing the five-and-a-half-hour gap (between 1:30am and 7am) where there was no air ambulance coverage in the East of England region.

The service audited dispatch times (999 call to HEMS dispatch) and launch times (HEMS dispatch to launch) monthly using its key performance indicator dashboard. They also tracked launch times separately for day missions (target 4 minutes) and night (softer targets acknowledging increased planning needed).

The National Institute for Health and Care Excellence (NICE) and *NHS England* standard for patients requiring rapid sequence intubation (RSI), is to achieve RSI within 45 minutes of the 999 call. The service had their own target for patients to receive RSI within 20 minutes of arrival at scene. These targets were tracked monthly and the service achieved 50% compliance in May 2022. Managers told us that the 45 minutes target was challenging to meet, due to delays in the dispatch process. The service was completing an evaluation project investigating the clinical and operational factors which influenced these two targets, to consider how best to use and monitor the targets appropriately going forward.

Staff acted to minimise the time people had to wait for treatment. The service had worked to improve their aircraft availability to be able to respond quickly and made modifications to the air ambulance to provide more comfort and less vibration in flight. The team aimed to get an air ambulance deployed in the daytime, in under five minutes. Deployment of the air ambulance at night took longer due to the increased risk and risk assessments that needed completion to keep staff safe when deploying the air ambulance. The team measured deployment times for its vehicles and routinely achieving above 98% compliance. Data from May 2022 showed the immediate dispatch time as 10.1 minutes, time to launch 4.6 minutes and 75.5% compliance with arrival at scene in less than 45 minutes.

Outstanding ☆

Emergency and urgent care

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 which was available by the services web site. The staff could also leave calling cards at a scene with the details of the services aftercare team in case anyone would wish to make a complaint.

Staff understood the policy on complaints and knew how to handle them. The service had received six complaints in the 12 months before our inspection. Two complaints were related to aviation, one diagnosis and treatment and two others not specified. Staff told us the main types of complaints related to issues such as damaged fencing when the air ambulance was landing or taking off, noise of the air ambulance and gave an example of how the teams had cut through some fencing to gain access to a scene and affected the electrical supply to a local property's electric gates.

Managers investigated complaints and identified themes. Managers were clear in their roles regarding investigating complaints. The complaints were sent to the individual department managers relative to the nature of the complaint so they could be thoroughly investigated. For example, complaints regarding the air ambulance went to the aviation and director of operations and infrastructure. Investigations into complaints were comprehensive and the service used innovative ways of looking into concerns, including using external people and professionals to make sure there is an independent and objective approach.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. All complaints were acknowledged in line 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 knew how to manage complaints, and often faced complainants on scene when approached by the public. For example, the complaint in relation to the electric gates was fully investigated, a detailed response provided, and compensation made for the damage. The team had implemented additional environmental risk assessments, especially at night to manage risks associated with complex scenes. 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 five patients and two relatives, the described the service as incredible, second to no one, lifesaving and life changing. They had no complaints about the service and said the after-care team had been a huge part in their recovery and in their patient journey.

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 newsletters and updates on its intranet. Front line staff would reflect on all 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 trustee's had oversight of all complaints and would often be involved in the complaint feedback process where needed.

The service had developed a comprehensive network of patient engagement groups and people who used the service were involved in regular reviews of how the service managed and responded to complaints.

Are Emergency and urgent care well-led?

Outstanding ☆

Emergency and urgent care

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 leadership structure, with clearly defined roles and responsibilities at all levels. The chief executive officer (CEO) led the service and reported to a board of trustees. The service had recently promoted internally to the role of CEO, the appointee was previously the Care Quality Commission (CQC) nominated individual for the service and had comprehensive knowledge of CQC regulation and inspection frameworks. All staff we spoke with told us the CEO was very visible, highly committed to the services aims and mission, extremely experienced in helicopter emergency medical services (HEMS), approachable to all and that they had spent time with people in all roles across the service in order to understand their needs and promote the services mission.

Leaders had the skills and abilities to run the service. The CEO led a highly experienced and established team including the medical director (registered manager), director of operations and infrastructure (nominated individual), director of people and culture, finance director and company secretary and a director of engagement and income. The registered manager and nominated individual were highly experienced and qualified within their roles. They 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.

During our inspection we observed compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated high levels of experience, capacity and capability within HEMS needed to deliver excellent and sustainable care. The service invested in the development of leadership roles across the service, including succession planning to create new roles and respond to increased demands within the service. Recent changes in the leadership structure had seen new deputy medical director roles created to manage capacity and improve performance.

Leaders were visible and approachable in the service for patients and staff. All 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 research or improvement projects. Volunteers we spoke with described working for the "Air ambulance family", that they felt part of a big team that was committed to offering lifesaving care. Volunteers felt valued and respected by all staff and the changes in the physical environment had brought the team together, so they felt more included in the service than ever before.

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. Leaders and staff understood and knew how to apply them and monitor progress.

Emergency and urgent care

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 service had a dedicated five-year strategy with the strategic intent *"Together with our donors, we will push the boundaries in pre-hospital emergency medical care to measurably improve patient outcomes across East Anglia."* The strategy was developed with the staff team, volunteers, patient groups and external stakeholders and was underpinned by strategic themes, key enablers and the strategic objective of meeting the services vision.

Staff we spoke with were aware of the strategic plan and managers had clear objectives and job roles designed to ensure the plan was implemented and reviewed. The service had a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. This was overseen by the trustees and progress reviewed within the clinical governance structures. The service had an up to date policy for the management of change, showing the structured process that the service used to manage significant changes within the service and risks associated with any changes.

The service mission is, "Together with our donors, we will push the boundaries in pre-hospital emergency medical care to measurably improve patient outcomes across East Anglia." All the staff we spoke with knew the services vision and the role the air ambulance and its teams played in providing pre-hospital lifesaving care. Managers told us they had involved key stakeholders and patient groups in the development of the services mission. Managers told us they valued the input from all groups into their mission and understood that a shared method for creation of this was vital to the success of the mission being implemented and achieved.

The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. The teams continued to provide HEMS throughout the COVID-19 pandemic and simultaneously completed a £7 million development of its location to provide training, rest and welfare facilities required for the first air ambulance in the East of England to fly round the clock. The strategy and plans 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 felt respected, supported and valued**.** All staff were committed and passionate about providing high quality care to patients and their relatives. Staff felt tremendously proud to work for the service and were positive about the work they undertook. 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 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 described how staff, patients, relatives, volunteers and trustees worked together to support the service and implement continuous improvement

Emergency and urgent care

The service promoted equality, diversity and inclusion (EDI) in daily work and provided opportunities for career development. The service had clear processes for promoting equality, diversity and inclusion in its work force strategy and amongst its volunteer group. The aftercare teams carried out equality monitoring for all patients and reported data to the trustees and managers to ensure they we are giving a good service to all members of the community and not marginalising anyone or restricting access to the service.

Staff we spoke with could articulate the importance of recognising diversity and the clinical team had taken additional steps to purchase medical mannequins to represent ethic groups to ensure staff could recognise the different effect of medical emergencies, for example the change in skin tone due to breathing difficulties.

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. Staff described the CEO as a role model for the services, promoting the professional standards required but also encouraging staff to immerse themselves in the service, enjoy coming to work or volunteering and taking pride in the success they had achieved.

The recent environmental changes at the location were focused on providing a "Hub" for all the activities carried out by the service. It enabled all people to access an environment that promoted positive and open interactions, encouraged mindful spaces for reflection and innovation, offered private spaces for those meaningful conversations with patients and relatives, and wellbeing spaces for personal fitness, fun and interacting with colleagues. The service placed a strong emphasis on promoting the emotional and mental safety and wellbeing of staff. HEMS staff often faced traumatic scenes in their day-to-day work. The service took a proactive approach towards staff mental and emotional wellbeing and provided a range of occupational health services, employee assistance programmes, counselling and wellbeing days.

Patients and relatives, we spoke with described a culture of providing outstanding aftercare, where staff went over and above their expectations of the service to ensure patients and relatives had the time and resources to manage their recovery or the recovery of a loved one.

In May 2021, the service was awarded first place in the Best Companies list for the Charity Sector for its exceptional employee engagement and support during the pandemic. The charity was also recognised as the sixth best company to work for in the East of England in the 2021 listings and fourteenth in the top 100 mid-sized companies to work for in the UK (for private companies and not-for-profits).The service ran annual staff surveys, surveys showed staff highly valued leaders, teamwork and working for the service. The service also carried out a dedicated staff survey to establish how it would manage its transition from the COVID-19 pandemic, and fully engage staff in making changes in services, reviewing actions during pandemic and reviewing how it would deliver its mission based on learning from the changes it implemented to maintain patient and staff safety.

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.

Emergency and urgent care

Leaders operated effective governance processes, throughout the service and with partner organisations. Governance arrangements were proactively reviewed and reflected best practice. 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 in key to improving services. There were clear lines of accountability for governance from trustees, through to the executive teams, and wider staff teams.

Four main areas underpinned the governance systems including operations, clinical operations, income generation and support services. Each of these four areas involved overarching governance processes including clinical operations, clinical governance days (CGD), research, audit, innovation and development (RAID), clinical governance steering group (CGSG), finance, information governance and data protection. Records we reviewed demonstrated that information and performance data from these groups was routinely reviewed by the services extended leadership teams, executive team and trustees. The service also had dedicated reporting lines within its governance structure for its major incident processes including Viper and Grass Snake, which were dedicated teams that executed the services business continuity and major incident plans.

The CGSG met monthly, and the service held a minimum of ten CGD annually. The CGD were open to all pre-hospital practitioners, students, and operational teams both internally and externally. Death and disability (D&D) meetings were held by the service to review complex cases, such as patients receiving blood products, paediatric cardiac arrests, inter-hospital patient transfers, to ensure the sharing of good practice and reflection on areas for improvement & change. These meetings were chaired by the service's medical director or deputy and findings were reported CGSG and shared at CGD. We reviewed CGSG minutes from June and May 2022, these were comprehensive and covered areas of clinical effectiveness, audit, research, education and training, patient and public engagement amongst others.

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. Trustee meeting records from April 2022, showed that the trustees had clear oversight of risk and performance and held managers to account to ensure risks were managed and being updated in line with the services governance and risk processes.

The service had a patient outcomes group (POG) which met monthly and included the head of service Improvement and clinical quality or nominated deputy, medical director, deputy medical director, head of community operations, medical education lead and research and development lead. The primary objective of the group was to ensure that the organisation had a robust framework for the review and analysis of patient care.

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.

Leaders and teams used systems to comprehensively manage performance. The service used a range of key performance indicators (KPI) to measure performance and identify where improvements were required and celebrate success. We looked at records, including governance meetings, trustee meetings, KPI reports and team meetings that showed the service monitored and pursued progress against KPI and challenged any no one 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. Risks were rated appropriately and had mitigations, time frames for review and named individuals responsible for updating and mitigating the risks. The risk register was

dynamic, and managers could manage the register in real time to reflect changing risks as they emerged within the service. All staff we spoke with knew what was on the risk register including response to the COVID-19 pandemic, doctor or paramedic unavailable due to long term issues, clinical staff who worked for the armed forces being redeployed and unable to fulfil their role in the service.

Staff and managers actively sought to research around risk and use innovation to make positive changes in the service. For example, the staff had introduced a raft of new processes to support air ambulance operations at night, improve deployment times and ensure staff and patient safety when carrying out missions in the dark. Problems were identified early, addressed quickly and openly to promote learning and minimise any ongoing risks.

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, in order to establish risks that had contributed to incidents and how to mitigate these in the future. The services Medical Workforce Strategy (2020-2025) related to risks in relation to the medical services work force and had developed a medical work force plan in order to manage these risks and recruit appropriate staff with the right skills, training and competencies.

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. Staff knew where to find these plans and knew their role in each of them. There were action cards that reminded staff what their role was in a major incident and all staff we asked told us were their card was stored. Managers told us they had 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 used a holistic approach to integrate their information management processes. The service had a digital audit system that tracked all their audit information which included information about cleaning schedules, incidents, safeguarding reports, and temperature logs. 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 where patient records and KPI details were recorded. 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 the entry, and ID badges provided.

The service had up to date data sharing agreements in place with key stake holder sin relation to HEMS, patient care and outcomes. Staff we spoke to 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.

Staff had training on how to keep information secure. We looked at records that showed all staff were given information governance and general data protection regulations (GDPR) training. At the time of our inspection staff were 100% compliant in both subjects. 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.

Engagement

Leaders and staff actively and openly engaged with patients, staff, 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 services culture. The service had a comprehensive range of engagement processes for staff, patients, relatives and external stakeholders to participate in and make developments within the service. For example, the services patient outcome group (POG) reviewed patient outcome data and provided guidance to the services research and audit group regarding up to date and relevant research and audit. Records we reviewed from the POG meeting in May 2022, showed there was consistently high levels of constructive engagement with staff and people who use service.

The service held a biannual staff day, to encourage interaction with all departments for service updates and team building. The day would include things such as presentations of recent commendations, presentations of long service awards, a presentation from the service chairman and CEO, patient stories and introducing new staff and volunteers to the teams.

The service had a Patient Forum Group (PFG) which met every three-months to provide feedback and opinion in relation to current practice and new innovations. The overall purpose of the PFG was to ensure that the views of patients and public were integral to the services decision making and provide constructive challenge and scrutiny of decisions from a patient and public perspective. The service produced a monthly magazine called “Lift Off”, which contained highlights from the service achievements, fundraising activities, patient stories and updates on the service.

The service effectively involved members of the public. The service website provided a large variety of information for the public including; patient stories, material about their team, and about the service’s history. They also took part in television programs that showed the wider public examples of critical lifesaving treatments provided by the air ambulance staff.

The service effectively involved over 200 volunteers. The fundraising team arranged and managed a variety of events to engage with the public and raise funds for the charity. Talks were provided to local schools and businesses to raise awareness of the services and one volunteer we spoke with told us how they used their professional work skills to deliver seminars and engagement activities with the public on behalf of the service.

The service effectively engaged with their local partners. The service held quarterly meetings with the local NHS ambulance service 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 that met local needs.

Emergency and urgent care

One of the main emergencies that the service was tasked to was patients suffering an out of hospital cardiac arrest. The service had a key aim to ensure that the public receive quality early cardiopulmonary resuscitation (CPR) from the public and professionals to provide the best possible patient outcome. The service offered Resuscitation Council UK standard Advanced and Immediate Life Support training for paramedics, doctors, nurses and other clinicians. It also provided community CPR sessions, teaching basic CPR, how to use a defibrillator and aimed to train 10,000 people locally over the next five years.

The service had a research, audit, innovation and development (RAID) strategy (2020 – 2025), that was linked to its mission. To achieve the strategies aims and objectives staff from within the service had to engage with HEMS across the UK and internationally to participate in research and development of the service.

Staff employed directly by the service could use two well-being days per year. The human resource team explained these formed parts of the services approach to staff wellbeing. Staff could take well-being days at any time, without fear of retribution, if they needed time off, were feeling low in mood or had dealt with a difficult situation on a mission. Managers encouraged staff to share their reasons for the time off, but purely in a supportive manner to establish if there were any underlying concerns regarding the staff wellbeing and these discussions remained confidential unless there was a cause for concern.

The service co-wrote and subscribed to "The McQueen Charter", to demonstrate its commitment and support in ensuring staff had access to appropriate services and resources to manage their mental health and wellbeing. The Charter is designed to guide HEMS on the best way to support the mental health of those who work in any role within the sector.

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 were committed to continually learning and improving services in order to save lives. Leaders encouraged the safe use of innovative and pioneering approaches to care and how it was delivered. The service proactively supported staff to take part in research as they felt this was key codeveloping HEMS 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 cosnistently 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 at the time of our inspection the service was involved in 17 research projects.

The staff had worked with specialist equipment manufacturers to develop equipment models and simulation systems to replicate real life situations in its Immersive Training Suite. The staff worked with other emergency services to run major incident scenarios, share learning and innovation to improve patient outcomes.

Outstanding ☆

Emergency and urgent care

The service was conducting an audit of night HEMS operations as part of a multi-disciplinary project looking at planning formulae for night HEMS operations.

The service was completing an audit on the comparison of deliberate self-harm incidents attended by HEMS before and during COVID-19 pandemic in the East of England.

The service was completing an audit of all patients who had undergone airway intervention in last five years and developing a monitoring dashboard to improve performance.

The service was evaluating the impact of inhalation of methoxyflurane (Penthrox) for the manipulation of acute traumatic orthopaedic/joint injuries.

The service was participating in the Trauma Emergency Thoracotomy for Resuscitation in Shock (TETRIS) study.

Managers were leading on audit on blood product administration, including audits and the development of key performance indicators.

The service was participating in the research of “Patient and clinician experience of pre-hospital care for traumatic brain injury (TBI) - TBI: An exploratory qualitative study and development of recommendations for best practice: Application to NIHR (EHAAT leading).”

The service was participating in the study, “The end-tidal and arterial carbon dioxide gradient in serious traumatic brain injury after pre-hospital emergency anaesthesia: a retrospective observational study.”

The service was participating in research titled, “Nurse-led Aftercare in a UK Helicopter Emergency Medical Service: a phenomenological study of patient, clinician and crew experiences.”

The service was carrying out audit into Investigating the effect of administering Lyoplas pre-hospital on patient outcomes.

The service was evaluating the factors associated with time to pre-hospital emergency anaesthesia in trauma patients.

The service was participating in the Specialist Percutaneous Emergency Aortic Resuscitation (SPEAR) case series review: audit of the feasibility and safety of early femoral arterial vascular access.

The service was participating in an audit of patients presenting with TBI and requiring intubation - development of key performance indicators.