Essex & Herts Air Ambulance Trust

# Essex and Herts Air Ambulance Trust

**Inspection report**

Earls Colne Business Park
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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 comprehensive mandatory training in key skills including the highest level of life support training to all clinical 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.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.
- 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.
- A proactive approach to anticipating and managing risks to people who used services was recognised as the responsibility of all staff. Staff identified and quickly acted upon patients at risk of deterioration. Staff completed and updated risk assessments for each patient and removed or minimised 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 staff a full induction.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- 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.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- 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 proactively monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients
- The service had a comprehensive system and process 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.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Key services were available seven days a week to support timely patient care.
- 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.
- 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 carers to minimise their distress.

# Summary of findings

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.
- People could access the service when they needed it, in line with national standards, and received the right care in a timely way.
- 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, including those in partner organisations.
- 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 vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- 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.
- 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 identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- 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.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- 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.

# 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. See the overall summary for details. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Essex and Herts Air Ambulance Trust

Essex and Herts Air Ambulance Trust (EHAAT) is operated by Essex and Herts Air Ambulance Trust, a registered charity, that provides a helicopter emergency medical service (HEMS) and rapid response service 365 days a year from its air bases in North Weald and Earls Colne. The service provides 24 hours 7 days a week life-saving critical care pre-hospital service by helicopters and rapid response vehicles (RRV) during the hours of darkness. 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 EHAAT staff to deploy the most appropriate resource to emergencies.

The service provides care to critically ill and injured patients in Essex, Hertfordshire and surrounding areas. Between 1 September 2021 and 31 August 2022, the service was tasked to 2,510 missions and treated 1,862 patients, 200 (11%) were children aged below 16 years and 1,662 (89%) were adults. As part of the services strategic aim to offer 24 hours per day, seven days a week cover by its air ambulance and rapid response vehicles the service operates a split shift pattern. During the day from 7am to 8.30pm the critical care team provides the service by helicopter from their Earls Colne and North Weald base. Overnight from 7.30pm to 7.30am the service is provided using the RRVs from the North Weald base.

The service has had a registered manager in post since 2011 and is registered to provide the following regulated activities:

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

We last inspected the service on the 30 January 2018 and did not rate the service.

## How we carried out this inspection

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 31 August 2022, at the Earls Colne base and on 6 September 2022 at North Weald base. We spoke with staff, volunteers, two patients and three3 relatives, reviewed 10 patient records including medicines and documents in relation to the safe operation of the service, for example policies and procedures.

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 aspects of outstanding practice in this service and some of these are detailed in the main body of this report. The following are some examples of the outstanding practice:

# Summary of this inspection

- The service had an open culture to reporting all types of incidents. They had a dedicated section of each governance day to looking at incidents reported. They used these reports to inform scenario simulation-based training. All staff took part in these governance days which allowed them to be involved with the investigation of all incidents even those not directly related to their own role.
- The service engaged with its partners with the aim of improving care to all patients. This included working with; local NHS trusts training their staff, police, air ambulance services across the globe and involvement in national and international research projects to improve care.
- The service had strong leadership that supported their staff and created a culture supporting a thoroughly patient focused team. Learning, research and innovation was encouraged at all levels in order to reach the highest possible standards of pre-hospital clinical care and improve patient outcomes.

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.

# 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

### 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 all staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training took account of current best practice in relation to pre-hospital emergency medicine so that patients received a range of lifesaving treatment and intervention in an emergency.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. At the time of our inspection staff were between 85% and 93% compliant for these modules. The service was also updating their learning disabilities awareness training module in line with the legal requirement introduced in July 2022 by the Health and Care Act 2022.

Managers continually monitored mandatory training and alerted staff when they needed to update their training. Head of clinical delivery and human resources team ensured staff completed their mandatory training. The service had a minimum compliance target of 80% at any one time for all staff. All flight doctors and critical care paramedics are expected to complete their statutory and mandatory learning as part of their onboarding process. At the time of our inspection the overall compliance rate for mandatory training was 91%.

If clinical staff were not on missions, they would engage in training activities daily to ensure they were up to date with best practice. The service had invested in a range of training resources that included medical mannequins.

### 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, using local safeguarding procedures whenever necessary.

All staff received training specific for their role on how to recognise and report abuse. Safeguarding children and vulnerable adults formed part of the mandatory training programme. All clinical staff completed level 3 training for both children and adults safeguarding. This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) and the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

The service had named safeguarding leads who were trained to level four safeguarding adults and children. All staff we spoke with knew who the safeguarding lead was and how to contact them.

The service had an up to date safeguarding policy in place which set out the responsibilities of staff and referred to legislation and national guidance. Staff had electronic access to the safeguarding policy.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with were clear on their roles and responsibilities on how to safeguard patients.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Patient electronic 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 teams.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff gave examples of when they had attended emergency incidents that involved multiagency approach to safeguard the patient or others involved in the incident.

### Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. The aircrafts, rapid response vehicle (RRV), and base locations appeared visibly clean and tidy. Cleaning records we reviewed showed they had been cleaned in line with the service's infection, prevention and control (IPC) policy. Staff used electronic recording system each time they carried out their daily cleaning.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning logs were centralised, and reports were reviewed by managers to ensure compliance.

The service performed well for cleanliness. Records showed that from January to July 2022, the service performed 100% compliance rate in all areas of both bases and its vehicles for hygiene and infection, IPC checks.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had an up to date IPC policy in line with current infection control guidance. Staff had a wide range of PPE, handwashing facilities, sanitisers and antibacterial wipes.

The service had a monthly deep clean programme for the rapid response vehicles 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.

We checked several sterile consumable items which were stored correctly, safely and were all in date.

Used items to be sterilised were placed in a lidded box clearly marked, to be sent for sterilisation to an external contactor.

Staff were issued with appropriate uniforms when they started with the service, including flight suits. The service had effective processes to maintain standards of cleanliness and hygiene when decontaminating uniforms. The service had a dedicated sluice area at both bases, which contained a washing machine and drying facilities. Shower facilities were available to allow staff who may be contaminated to remove a contaminated uniform. A 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.

Staff had access to a changing room and shower facilities at both bases.

### Environment and equipment

**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.**

The design of the environment followed national guidance. The service built a new air base at the North Weald site in 2021 as part of the long term strategy for the service. The new build incorporates high specification facilities for aircraft, vehicles and crew, the building also includes space for training, mentoring, patient liaison and cross-training with other emergency services, which will benefit both EHAAT and the local pre-hospital care community. The service also undertook improvement works to their facilities at the Earls Colne airbase.

The design, maintenance and use of the premises kept people safe. The design of the air bases considered the flow of activity.

The North Weald airbase also provides a visitor centre which allows the service to welcome and engage with the local community and supporters. The new build has also helped to bring the fundraising team to work more closely with their clinical colleagues.

Clinical staff now had sleeping quarters that had been specifically designed to promote their wellbeing and increase their comfort. The service had 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 shower facilities. The sleeping quarters were away from the clinical area and also had a study area with computer terminals, for doctors or paramedics that might be preparing for exams.

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.

# Emergency and urgent care

The service has a state of the art training suite which used technology to project simulation images onto the walls to simulate various scenarios for example a road traffic accident on a busy road, which gave the illusion that the staff training were in the middle of the motor way. Staff were able to change the scenarios, including the environment lighting, sound, temperature etc to simulate the conditions that staff might encounter on a mission.

Staff were trained on the use of all equipment. During induction training staff were trained in the equipment used by the crew and then tested. Managers told us if staff were still unsure, they provided additional training focused on any equipment that the staff were struggling with. A competency assessment was completed by all staff as part of their critical care competency passport sign off. The service had separate equipment for training that were clearly labelled and stored separately to the ones used on patients.

Staff carried out daily safety checks of specialist equipment. We saw equipment check records and these were reviewed by managers for compliance.

Equipment storage areas were clearly labelled and well organised. The service had clear systems and processes in place to report and remove any defective equipment from service.

The service ensured that all vehicles had current MOTs, services and insurance certificates. The service stored vehicle records on their electronic database that showed all response cars had up-to-date MOT and insurance certificates and servicing was up-to-date. The system alerted the operational support team when vehicle checks were due.

The service ensured their aircraft were suitably serviced and checked in line with the Civil Aviation Authority regulations. The Civil Aviation Authority regulates all aspects of aviation.

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 maintenance and use of equipment kept people safe. The service held up-to-date records of equipment maintenance and schedules. We looked at records that showed the equipment had been serviced in line with the manufacturer's guidelines.

The service carried blood for transfusion as part of their emergency care response. The service had worked with the local blood suppliers where blood could be safely dropped off by the couriers, without entering the building using a 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 ensured that blood products were not wasted.

The service had access to advanced technical equipment. The service had recently purchased night vision goggles, so the pilots and clinical staff could effectively respond to calls, by air, during the hours of darkness. At the time of our inspection training was underway and the plan was to be fully operational during the hours of darkness by spring 2023.

The night vision goggles were protected by the International Traffic in Arms Regulations, so the service had to secure them safely on the premises. The security arrangements were robust. The night vision goggles were kept in a secure room and access to this room was only given to authorised personnel. The night vision goggles were kept in a locked cabinet that could only be accessed with a code.

Staff disposed of clinical waste safely. Staff followed the services IPC policy in relation to waste segregation and the disposal of sharps. All kit bags contained clinical waste bags and a sharps bin. We checked bins within clinical preparation areas at the base and waste had been correctly segregated. The area where clinical waste was stored was clean, tidy and secure. An external contractor was responsible for the final collection of clinical waste.

### Assessing and responding to patient risk

**A proactive approach to anticipating and managing risks to people who used services was recognised as the responsibility of all staff. Staff identified and quickly acted upon patients at risk of deterioration. Staff completed and updated risk assessments for each patient and removed or minimised risks.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patient clinical observations such as blood pressure, pulse rate, and respiratory rate were recorded on the electronic monitors used at scene to allow for early detection of deterioration in a patient's condition.

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 these 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.

Staff identified and responded appropriately to the changing risks to people who used the services. Vital observations were continuously monitored so the crew could quickly detect the deteriorating patient. The electronic system created a graph that clearly showed the observations presented deterioration. This monitoring was constant and removed the risk of missing significant observations during intervals. The service also had a system that allowed this information to be sent for a consultant to review the information. This allowed the consultant on call to provide clinical advice via telephone and monitor the patient's condition and alert the crew on the ground to any trend they had missed. The crew used this process to access specialist clinical advice when on scene and during transit. Staff told us support by consultants was effective.

Staff used the Glasgow Coma Scale to assess impairment in consciousness levels and a variety of clinical protocols for specific conditions to ensure all clinical risks were considered. The GCS is an assessment of consciousness using a set of three quick assessments that were standardised nationally. This allowed all staff from the service and any partner services at the scene to understand the patient's condition and the significance of any deterioration. Records we looked at showed staff had used the tool in line with national guidance. Staff we spoke to were confident in identifying deteriorating patients.

The service managed risks positively. Two clinicians routinely performed a 'challenge and response' risk assessment. One challenged the other by asking if equipment was prepared or present and the other checked that it was. Staff told us that this challenge and response ensured that everything was in place before performing a procedure or before leaving a scene in the midst of often busy environments and thereby helping reduce the risk of human error.

There was a safe and effective escalation process for deteriorating patients or situations that were beyond the abilities of one crew. Additional resources could be asked for via the Helicopter Emergency Medical Service (HEMS) desk which was located alongside the NHS ambulance trust critical care desk. The critical care desk could call in support from other services. In most circumstances, HEMS were the most competent team to manage the seriously ill patient in the pre-hospital setting. Additional resources were asked for if the number of patients was too high for a single HEMS team to manage safely.

# Emergency and urgent care

Staff knew about and dealt with any specific risk issues. The service responded to patients with serious injuries and some of these patients that had bled a large amount would normally have to wait until reaching hospital to receive blood products to replace the blood they had lost. The service had a standard operating procedure for major blood loss. The service however had a service level agreement to carry blood and blood products and give these to patient at the incident location. The service audited that blood and blood products are handled and used safely inline with current best practice guidelines, including blood products traceability.

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 intervention, staff could rapidly sedate and manage the airway of the patient. This meant crews could intervene in a controlled manner.

The service used technology and investment to reduce the risk of encountering adverse weather during transport via helicopter. The service had a digital display covering a large wall that showed the current weather conditions and via a touch screen interface could display more detailed weather reports. The service had also set up weather stations of their own at significant locations to the service to get detailed reports of weather to inform flight safety.

## 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 staff to keep patients safe. They had enough critical care paramedics, doctors and pilots to cover shifts that provide an enhanced care team response 24 hours a day, seven days a week. Each critical care crew consisted of a pilot and co-pilot, when responding by helicopter, alongside a prehospital care doctor and a critical care paramedic.

At the time of the inspection the service had 8 Helicopter Emergency Medical Service (HEMS) pilots and co-pilots, 24 prehospital care doctors and 17 critical care paramedics (CCPs).

The prehospital doctors were placed with the service by the deanery as part of their pre-hospital emergency medicine (PHEM) sub-speciality training. Of the 24 prehospital care doctors 9 were seconded to the service full time and 3 were emeritus doctors. The remaining 11 were consultants, 3 of which were governance leads for the service and 1 who was the medical director for the service.

Of the 17 CCPs, 12 were seconded to the service by the local NHS ambulance service trust and 5 were permanently employed by EHAAT.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. Managers ensured that there was always two fully staffed crews. The service had a number of emeritus doctors and paramedics that have completed their fixed term secondment but maintain their competence by undertaking regular shifts and attending clinical governance events with EHAAT. Emeritus staff would be contacted if staff were unavailable to work due to sickness or to cover other unexpected absences.

The service had low vacancy rates. At the time of our inspection the service had full staffing for all roles apart from the head of patient safety and quality. The service was in the process of reviewing and recruiting for this role.

As a registered charity the service had over 400 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. Volunteers received full induction.

Managers made sure all staff had a full induction and understood the service. We spoke with staff that had recently joined the service and they reported having a thorough induction and had the opportunity to gain experience of other roles and responsibilities of other people within the organisation.

## 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 10 patient records that demonstrated staff had completed them clearly with medicines and interventions clearly recorded. Patient records were completed on scene on an electronic system, which was accessible across a range of devices back at the services location.

The consultant of the day, as part of the service's clinical governance processes, reviewed each patient record. 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.

When patients transferred to a new team, there were no delays in staff accessing their records. Arrangements for recording triage decisions were clear. Transport locations were clearly noted in the patient clinical record. The receiving hospital was provided with an electronic copy.

Records were stored securely onto the system. Staff had individual usernames and passwords to access the records securely.

## Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the service's policy for the management of medicines and saw it was version controlled and had been modified in November 2021. The policy was comprehensive and gave information regarding: the prescribing, storage, and dispensing of medicines; controlled drugs (CDs); record keeping; adverse drug reactions; and audits.

The service used electronic patient records to log any medicines prescribed and administered during a mission. We reviewed 10 patient records which showed that medicines had been prescribed, administered and recorded in line with provider policies and national guidance.

When handing over patients to the receiving hospital, information about medicines patient had been administered is also provided electronically. This meant that the hospital team could continue to treat the patient appropriately.

The service ensured that medicines were ordered safely and securely. The service had a service level agreement with a local NHS trust that supplied medications for the service.

The service ensured medicines were only accessible by authorised personnel. Medicines were kept in a locked room and only clinical staff with authorised swipe cards and a security code could access this room. The system logged all entries to the room and provided this information to managers, so they could monitor which staff entered the room and the timings of access. The room was also monitored with 24hour video surveillance.

The service ensured that controlled drugs (CD) were stored safely and secure. Controlled drugs are medicines that can be misused and therefore need special management and secure storage to prevent any unauthorised access. The service kept controlled drugs in a locked cabinet within the secure medicines room. We saw the keys were kept in a safe, secured by a pin entry system. The medicines we looked at were within their expiry date and the stock levels were accurate. The service had an up-to-date home office license for the storage of their medicines.

The clinical crew kept the medicines including controlled drugs in grab bags which were tagged to ensure that tampering was identified immediately. The clinical crew always kept the medication grab bag with them and stored it securely within the aircraft and rapid response vehicle when in transit.

The service ensured that medicines were safely stored at appropriate temperatures. Fridge temperatures were checked electronically and logged the temperature continually . Staff checked these records daily to ensure the fridge remained within safe limits. The medicines store room temperature was monitored to ensure safe storage of medicines in cupboards. The room was air-conditioned and had a maximum temperature range that was also monitored daily. We looked at records for the last seven days that showed fridge and room temperatures had not gone out of their target range.

Staff learned from safety alerts and incidents to improve practice. There was a system in place to action medicine safety alerts and recalls.

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.

### Incidents

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

Staff knew what incidents to report and how to report them. There is a genuinely open culture in which all safety concerns raised by staff and people who use service are highly valued as being integral to learning and improvement.

Staff raised concerns and reported incidents and near misses in line with provider policy. We looked at the service's incident reporting policy that was up-to-date and had a date to be reviewed. Incidents were reported on the service's electronic reporting system which was accessible by all staff. All staff we spoke with knew how to report an incident and told us about incidents they had reported recently.

We reviewed 6 incident reports on site during our inspection which showed staff raised concerns, reported incidents and near misses in line with the services incident reporting policy. In the 12 months before our inspection the service

reported 314 incidents. Most incidents related to medical equipment and devices, medicines, estates and facilities and aviation. 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.

All staff we spoke with were open and transparent, and fully committed to reporting incidents and near misses. Learning was based on a thorough analysis and investigation of things that go wrong. 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. For example, the service was part of the study looking at significant mental health impact of the COVID-19 pandemic. The primary aim was to compare the incidence of deliberate self-harm incident (DSH-I) encounters by HEMS before and during the first wave of COVID-19.

The service liaised with the local NHS ambulance service to investigate and learn from incidents. The service investigated any incident that involved both services and then the two organisations liaised to share reports and learning.

Staff met to discuss the feedback and look at improvements to patient care. Staff discussed all incidents at their clinical governance day. These days involved discussion of all incidents that have occurred since the last governance day and updates on any unresolved incidents from the previous meeting. These days also consisted of simulation training relating to a recent hot topic or an incident that had occurred and would be focused on the learning that had arisen from these. Staff told us these days were very valuable to learning about how to improve from incidents. The service also used information about incidents that had occurred at other organisations to inform these training simulations.

Other external organisations were actively engaged in assessing and sharing learning from incidents. The service shared learning widely within the trauma network. The service had links with multiple major trauma centres across the South East. A major trauma centre is a specialist hospital with consultants who have expertise in the treatment of the most severely injured patients.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were no incidents reported to meet the threshold for the duty of candour.

## 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.**

# Emergency and urgent care

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had a broad range of clinical guidelines based on National Institute for Health and Care Excellence (NICE) or Joint Royal Colleges Ambulance Liaison Committee (JRCALC) good practice.

The service provided various standard operating procedures (SOP) for differing treatments and procedures. We reviewed a selection of policies and clinical guidelines and saw that they were version controlled, were within review date and contained up to date referencing. Staff we spoke with knew about these standard operating procedures and knew how to find them if they wanted to refresh themselves on the information.

The service was assured that new staff had read and understood policies and procedures. On induction, the service sent out all clinical guidelines and policies to new staff. If there were any updates or changes to clinical guidelines or policies, then this was sent to all staff through the electronic system. Staff acknowledged receipt, electronically, to show they had received and read the changes.

Staff who were working remotely had access to guidelines and protocols on a tablet device. This had internet access to the service drives that held all standard operating procedures and service policies.

Care was regularly monitored to ensure it was in line with evidence based, guidance, standards and best practice. This was monitored through document reviews, supervision and through discussion at clinical governance review meetings. On call consultants reviewed all patient clinical records and completed supervisory attendance on jobs to ensure that care was being performed in line with guidance and legislation.

Clinical guidelines were discussed at clinical governance meetings. This meant guidelines were reviewed and aligned with real life scenarios and the practicalities of dealing with traumatic events.

The doctors and critical care paramedics (CCPs) encouraged to develop a research project as part of their work plan and contribute to journals and conferences. Research was presented to the clinical teams and shared in the wider forums.

For example, the service has recently opened the EHAAT centre for excellence which aims to develop a framework to improve the health outcomes from illness and injury by improving the standards of prehospital clinical care through research, innovation and education.

## 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 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 prescribed, administered and recorded pain relief accurately. The patient records we looked at showed that patient pain was monitored, and medication was given to prevent patients being in pain.

The patient we spoke with, who had suffered significant injury, told us they had been given pain relief and could not recall being in pain while being treated by the air ambulance crew.

Outstanding ☆

# Emergency and urgent care

## Patient outcomes

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

The service participated in relevant national clinical audits.Information about people's care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. The service used this follow up data to assess the effectiveness of care given on scene and how that care influenced patient outcomes.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service routinely collected and monitored information about people's care and treatment, and their outcomes. This information was used to establish if care had been effective, and what impact the care and treatment had on patients longer term outcomes. The service participated in local and national audit and research to assess the effectiveness of care given on scene and how that care influenced patient outcomes and shared this with other hospital emergency services to make improvements in the service. One example was the research on cardiovascular complications of pre-hospital emergency anaesthesia in patients with return of spontaneous circulation following medical cardiac arrest. This was a retrospective comparison of ketamine and midazolam based induction protocols. The outcome of the research was published on a peer reviewed journal and shared in various forums.

The service reported difficulty in reporting patient outcomes once patients had been received at a hospital, as they often were unable to access on going patient data from receiving hospitals. The patient liaison team were able to provide some qualitative feedback and acted as a conduit to patients to allow more formal feedback and research in the future.

The service was working collaboratively with the local NHS Ambulance Service and other HEMS services on audit, service evaluation and research. As part of this collaborative activity, the services share anonymised data for key areas, including airway management in trauma and out of hospital cardiac arrest. For example, the cardiac arrest patient outcome data has been used within several projects within EHAAT, including a service evaluation comparing demographics, etiology, presenting rhythms and outcomes of out of hospital cardiac arrest between the initial COVID lockdown and a comparison period. This study was recently published in the Air Medical Journal. The outcome data have also been used in a review of pre-hospital thrombolysis delivered by EHAAT, to compare outcomes between out of hospital cardiac arrest patients who receive thrombolysis and those who do not. Findings will help to inform practice and will be disseminated through a peer-reviewed publication.

The service had strong links with other providers and bodies who monitored and compared patient outcome data. The service engaged with the Trauma Audit and Research Network and had information sharing agreements with the major trauma centres to monitor patient outcomes.

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, and vehicle safety 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.

Managers shared and made sure staff understood information from the audits. Audit outcomes were a key part of feedback in the service's 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.

Outstanding ☆

# Emergency and urgent care

## Competent staff

**The service had a comprehensive system and process 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 human resources department required suitable references. These were held in electronic staff files by HR. Staff selection took place through a number of assessments. This meant that staff were selected based on an assessment of different areas of competence, skill and experience required for the role.

The service ensured that staff had the required disclosure and barring (DBS) checks. DBS checks were processed by HR before staff started induction. These checks were completed every three years and held in their electronic staff file. All staff files had up to date and suitable (DBS) checks.

Driving licenses were checked before induction and yearly thereafter. These checks were recorded on the individual electronic staff record and repeated annually. Staff also had a duty to report any reason that may disqualify them from driving trust vehicles. As well as the NHS blue light training which they received prior to commencing with the service the CCPs and clinical managers all undertook advanced emergency responder driving provided by an external provider.

The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. All staff were able to attend a clinical governance day every month depending their availability. This day included case reviews, shared learning, skills sessions, training scenarios, simulation and topic teaching. Staff attendance was logged, and this contributed to their continued professional development.

The learning needs and aspirations of staff were identified, and training plans were developed to meet them. Staff were encouraged to speak openly about any learning needs and told us they felt able to suggest learning areas for upcoming governance days.

The service had arrangements for supporting and managing staff. This included one-to-one meetings, clinical supervision and appraisals. For example, staff competence in delivering patient care was assessed through direct consultant supervision of their practice.

Annual appraisal rates for the CCPs directly employed by the service was 100%. Staff we spoke with said that appraisals were meaningful and that they found them useful in developing their careers. They also reported that the service was supportive of accessing courses and training needs as identified.

The service had oversight of seconded doctor's appraisals with information sent from the parent organisation. To support doctor and CCPs appraisals, the service had developed an additional form to document their practice conducted with EHAAT.

All new employees and crew received a service induction. We reviewed the induction procedure and saw that it was comprehensive included introduction and briefing with the relevant teams within EHAAT.

Experienced critical care paramedics supervised all new members of staff and pre-hospital emergency medicine trained doctors and were supernumerary during their induction period. Then they were supervised to complete their clinical competencies. Managers told us that the induction would be extended if needed to enable the staff to develop the skills required for the role.

The clinical teams maintained and improved their skills outside of missions via a range of practical scenario sessions, which they rehearsed between missions. The service provided equipment that could be used for training and these items were made available at the helicopter bases. We observed doctors and paramedics discussing various training scenarios and situations they wished to practise during the day.

### Multidisciplinary working

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

We did not see a handover between the air ambulance staff, road crews or hospital staff during our inspection. EHAAT crew handover patients to the receiving hospital using a standard set of prompts; this meant staff handed over patients using a consistent approach.

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 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.

The service was committed to working collaboratively and found efficient ways to deliver more joined-up care to people who used services. Due to the nature of pre-hospital emergency medicine, EHAAT 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. Staff recognised the need to respect the road crews they worked with and the need to act as support and guidance when on scene.

Staff told us they worked collaboratively to understand and meet the range and complexity of people's needs. Staff we spoke with told us that when they arrived on scene, they made a note of their resources and skill levels then delegated everyone a role to suit. The team were encouraged to include all members of staff on scene, this ensured that the HEMS staff had good oversight of the scene and used the variety of skill levels to the patient's advantage.

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

Staff included the local NHS ambulance road crews as part of their governance days and scenario training. The service also uses the centre for excellence training suits to support and help train staff from other services. Managers told us of one example where staff assisted in training the local police firearms unit.

### 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 using helicopters and rapid response vehicles (RRVs).

Outstanding ☆

# Emergency and urgent care

During the day, 7am to 8.30pm, the critical care team operates from both the Earls Colne and North Weald bases. Overnight, from 7.30pm to 7.30am, the service is provided through the RRVs from the North Weald base.

### 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 the relevant consent and decision-making requirements of legislation and guidance. The service had an up to date consent to examination or treatment policy.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff had a good understanding of the Mental Capacity Act and acted in the patient's best interests if they were unable to consent. Staff clearly recorded consent in the patients' records.

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 help patients to involve them in decision making and support them by explaining complex medical information in simpler ways.

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.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, 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. Staff could also contact the consultant on call for additional advice on any areas of capacity or consent whilst on missions.

Staff completed comprehensive training in capacity and consent. At the time of our inspection, 93% of staff had completed this training. Refresher training took place annually.

## Are Emergency and urgent care caring?

Outstanding ☆

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

### Compassionate care

**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.**

Staff were discreet and responsive when caring for patients. There was 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 cut a patient's clothing off to fully assess their injuries but that they would if 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 doing their assessment they would cover the patient up afterwards.

Relatives and patients we spoke with told us they recall having their clothes cut off during the examination process, but that the crew quickly covered them with a blanket.

Patients and relatives said staff treated them well and with kindness. The patients we spoke with told us they didn't recall much of their care due to the nature of their injuries however, one said they recalled the crew being " very kind".

Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. People thought that staff go the extra mile and the care they received exceeded their expectations. The 2 patients and 3 relatives we spoke to were overwhelmingly positive about the care that they or their loved ones had received. When talking about their feeling about the way the crew looked after them one patient told us "they are truly amazing".

### Emotional support

**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 carers to minimise their distress.**

Staff gave patients and those close to them help, emotional support and advice when they needed it.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.

The patient and family liaison team (PFLT) provided support and guidance to patients and their families, if they wanted to, as part of an aftercare service and in the community. EHAAT's patient and family liaison team offer support, not only in the short term but for as long as it is required to patients and their families. Support was offered in various forms such as; phone calls, face to face meetings, bedside meetings at hospitals, EHAAT base visits and signposting to relevant organisations.

The PFLT was made up of paramedics and senior nurses with extensive experience. 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. 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.

Staff described how they gave patients and those close to them help, emotional support and advice during their episode of care. However, once the patient had been transferred to the receiving hospital or discharged from hospital the patient and family liaison team would get involved.

One of the patients we spoke to when talking about their experience of the PFLT said the support provided was "amazing". One relative described how supportive they were with their loved ones when they had a cardiac arrest. When the EHAAT crew arrived, they took over the scene but treated the relative as a part of the team and took a debrief from them regarding the situation.

Outstanding ☆

# Emergency and urgent care

The patients and the families we spoke with told us that after making a recovery they visited the service and met some of the crew who helped with their care. This had been facilitated by the PFLT and they all reported this has helped them emotionally with their recovery. Patients told us about meeting crew that had provided them with care on the day of their injuries. They explained this had helped them fill in the gaps in their memory of the events of the day.

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.

The service welcomed patients and their relatives to volunteer and to raise money for the charity. Patients found this experience highly rewarding. We spoke with volunteers who have been EHAAT patients and as a result of the help and support they have become a volunteer for the service. They said that this was a very rewarding experience for them and would stay with them for a long time.

The PFLT where appropriate will also support bystanders and strangers, for example who might have alerted the emergency services or started CPR until the ambulance service arrived. Often bystanders also needed emotional support due to the trauma they witnessed, and the PFLT 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. People who use the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Patients and relatives told us they had been kept as informed as possible of the treatment being given. However, staff told us that often their patients were unconscious.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff told us they gave out aftercare cards to patients and relatives with their contact details on and that they had leaflets for any patients that wanted to give feedback. Over the years the service also recognised that often patients and their families were keen to contact and give their compliments to the crew. In response to this, the service set up a 'Thank the Crew' section on their website so that messages could be left and responded to, if appropriate.

The PFLT showed us several examples where they had contacted patients and relatives to engage them in the aftercare process. The 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.

## Are Emergency and urgent care responsive?

Outstanding ☆

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

Outstanding ☆

# Emergency and urgent care

## Service delivery to meet the needs of local people

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

The service planned and organised services so they met the needs of the local population. The service has been developed around the number and type of pre hospital medical emergencies that happened across the East of England region. This meant the level of staffing, types of aircraft and rapid response vehicles used were all inline with needs of the local population.

The service worked with other providers to support them to meet demand. EHAAT worked in partnership with the local NHS ambulance trust, who would dispatch the EHAAT critical care team according to clinical need. Staff told us that they worked in collaboration with road crews from the NHS ambulance trust to care for and treat patients. When it was not possible to transport patients by air, the NHS trust staff transported patients by road in their road ambulances while EHAAT staff travelled in the road ambulance to continue patient care.

The services provided and reflected the needs of the population served. The service regularly monitored and engaged with other pre-hospital emergency services and acute NHS trusts. This allowed them to analyse when demand was at its peak. 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 two response crews and these crews did staggered shifts so that there was always a crew ready to respond. This also allowed the crews handing over to not feel pressured to finish in case a call came in while they were handing over.

Facilities and premises were appropriate for the services being delivered. As part of the service's strategy, the service has upgraded its emergency vehicles, commissioned a new build for the North Weald base and upgrade its existing facilities at the Earls Colne base. 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 new build at the North Weald base has given space for training, mentoring, patient liaison and cross-training with other emergency services, which benefits both EHAAT and the local pre-hospital care community.

The service had suitable facilities to meet the needs of patients and their 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 training space at the North Weald site 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. The office space was set up in a way to provide mindful spaces for people to interact and promote a positive environment for people to work and learn in.

The service had an interactive visitor centre which is open to the public for tours and help for the service to engage with their supporters.

Outstanding ☆

# Emergency and urgent care

## Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.**

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.

Interpreting support was available for staff in the treatment of patients whose first language was not English. Staff had access to a language interpretation telephone support team who provided language interpretation for healthcare. 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.

Staff considered people's needs when they visited the service. The service had a number of patients and relatives visit the base to ask questions or offer their thanks. The service recognised it was not suitable to meet patients and relatives in the office setting. The service had a patient and relatives' room which had comfortable sofas and pictures. The crews and managers used this room to talk with patients and relatives when they visited the base.

## Access and flow

**People could access the service when they needed it and received the right care in a timely way.**

Access to the EHAAT service was via the 999 NHS ambulance trust emergency operations centre. Within that centre, the critical care desk (CCD) sat alongside the NHS ambulance trust's dispatchers and was managed by critical care paramedics and dispatchers. The CCD staff screened all calls that came into the centre and assigned the Helicopter Emergency Medical Service (HEMS) team to jobs that fitted their criteria for tasking.

Managers monitored response times and made sure patients could access emergency services when needed and received appropriate treatment.

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.

The service effectively measured tasking efficiency by monitoring the number of jobs they classified as missed. Missed jobs were incidents identified as where one of the services resources was not immediately available to respond because of already being committed to another incident. Any job that was flagged as a miss was reviewed by managers.

Patients had timely access to urgent treatment. The staff and management team placed high importance in ensuring calls were quickly assessed and dispatched. Managers told us they would rather crews were stood down after dispatch than delay critical intervention to a patient while criteria were debated.

## 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, including those in partner organisations.**

Outstanding ☆

# Emergency and urgent care

Patients, relatives and carers knew how to complain or raise concerns. The service had a process for handing complaints and concerns. Patients were able to make complaints in writing, electronically or verbally. The service had a policy for the management of complaints which was up to date. Staff knew about the policy and knew how to advise patients if they wanted to make a complaint.

Staff could also leave calling cards at a scene with the details of the services patient and family liaison team (PFLT) in case anyone would wish to make a complaint.

The service did not receive that many complaints. In the last 12 months before our inspection the service received a total of 5 complaints. Of these 4 related to operational/aviation, where fencing or property was damaged when the air ambulance was landing or taking off and complaint related to noise.

One complaint from another organisation related to a communication between the clinical team. We saw the investigation report into this complaint, and it was not upheld. Investigations into complaints were comprehensive and were in line with the complaints policy.

Lessons were effectively shared internally. All complaints from patients and feedback were investigated and reviewed at the clinical governance group. Feedback was shared with the staff involved and learning was shared to the rest of the staff through emails, minutes and discussion at governance days.

## Are Emergency and urgent care well-led?

Outstanding ☆

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

### Leadership

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

The service had a 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. All staff we spoke with told us the CEO was very visible, highly committed to the services aims and mission, 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.

The CEO led an experienced and established team including the medical director, director of operations, people director, finance director and fundraising and marketing director.

The leadership team were highly experienced and qualified within their roles. The medical director had overall responsibility for all clinical activities of the service and was supported by the clinical director.

Day to day operations of the service was monitored by heads of services. All of the heads of services held the relevant trauma and pre-hospital emergency medicine qualifications and experience.

The head of clinical delivery was also the CQC registered manager. 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.

Leaders were passionate about their roles and executed them with care and commitment to their staff. All staff could identify the different leads along with their roles and responsibilities. All staff had a visibly supportive and positive working relationship with the leadership.

During our inspection, we saw the management team were visible, supportive and had good working relationships at all levels. Managers told us they encouraged an open culture and actively sought staff feedback and opinion. 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.

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 "a big family", that they felt part of a big team that was committed to offering lifesaving care. Volunteers felt valued and respected by all staff. Staff at North Weald base told us the changes in the physical environment had brought the clinical and fundraising 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 and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The service had a vision and a mission statement, which was to "save lives, reduce or prevent disability, or suffering from critical illness and injury, by delivering a first class pre-hospital emergency medical service to the people of Essex, Hertfordshire and surrounding areas".

The service's vision and mission statement were underpinned by its values which included passionate, trustworthy, professional, dedicated, innovative and inclusive.

Staff we spoke with were aware of the vision and 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 strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

The service continued to provide HEMS throughout the COVID-19 pandemic, second staff to support the wider health care service during the Covid-19 pandemic and simultaneously completed a £4.5 million development of its North Weald location on time and within budget.

The development of the North Weald base not only provides ample space for training, rest and welfare of staff but also created the hub for the EHAAT centre for excellence. The EHAAT centre for excellence aims to develop a framework to improve the health outcomes from illness and injury by developing standards of pre-hospital clinical care through research, innovation and education with in the pre-hospital care community.

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.**

The culture within the organisation was overwhelmingly supportive and positive. There was a genuine culture of wanting to provide the best care for patients and desire to improve services. Staff from the most senior, to the most junior posts were passionate about the service provided.

Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff. In the annual staff survey (2022), 96% of staff said they were proud to work for EHAAT.

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.

There was a strong emphasis on promoting the emotional and mental safety and wellbeing of staff. Colleagues or managers debriefed clinicians after their missions. EHAAT recognised that that some missions could be distressing for staff and it was obvious that staff supported each other. 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. There was a strongly supportive culture from the most senior level down and staff had access to both the chaplain and an independent counselling service.

Staff and teams worked collaboratively and shared responsibility to deliver good quality care. Staff were encouraged to work as a team and make decisions together. The service encouraged paramedics to lead on a variety of jobs. For example, this was evident in the workstreams that were being established through the centre for excellence. Research within the organisation was led by both paramedics and doctors, which further reinforced the collaborative relationship between the crew.

The learning culture was embedded and supported by monthly clinical governance meetings, weekly death and disability review meetings and monthly clinical/pathological correlation death and disability review meetings. The service also hosted learning events and there was an open invite to external clinicians with an interest to attend. All staff told us they had access to learning opportunities.

# Emergency and urgent care

Leaders have an inspiring shared purpose and strive to deliver and motivate staff to succeed. The leaders of the service felt proud of how cohesive their team was. They told us about the way that their staff, patients, relatives, volunteers and trustees worked together to support the service and continuous improvement. The leaders supported junior staff to develop and viewed this as a positive step towards ensuring the service has the staff with the skills needed to deliver the service in the future.

## Governance

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

Leaders proactively reviewed and operated an effective governance process throughout the service. A systematic approach was taken to working with other organisations to improve care outcomes.

The board of trustees had overall responsibility for the service. The framework showed strong lines of reporting information both up and down the organisation. Medical, clinical, service delivery and risk management meetings all fed into the senior management team, who filtered key information to the board through sub committees.

The service held monthly clinical senior leadership and clinical risk and safety committee meetings both attended by key members of the executive leadership team. This ensured the executive team were informed of information regarding achievements and incidents from the frontline level.

Daily clinical governance at EHAAT was effectively achieved through a multifaceted structure. This included consultant of the week, incident reporting, on scene consultant advice provided 24hrs, death and disability meetings and clinical governance days.

Managers and clinical leads also reviewed clinical learning at clinical governance group meetings, which were held monthly. This ensured that clinical practice continuously improved.

Meetings were effective and responsibility for actions were efficiently delegated . The structure was well understood, and meetings were held routinely and regularly. Minutes we reviewed showed that adequate time was given to each meeting, with each meeting having an action log. Each action log identified the action to be taken, the named owner, the current status and any updates.

Staff were clear about their roles and understood what they were accountable for. Every standard operating procedure we reviewed detailed responsibilities of staff in varying roles. All the policies we reviewed were in date, current and ratified. There was also evidence of regular updates to standard operating procedures and any changes were effectively communicated to staff. All staff we spoke with understood their role and could tell us what their responsibilities were including the responsibilities of each committee and meeting.

There was a complete understanding of performance. The governance structure was set out to review and monitor a wide variety of areas including safety, quality, activity and financial information. We reviewed meeting minutes and noted that the service had oversight of these areas and they were discussed throughout the governance structure in relevant meetings.

The board was given a report of performance at every meeting and had a full and thorough understanding of performance. Senior leaders we spoke with felt they were adequately challenged at board level.

# Emergency and urgent care

The service used an external team of advisors and an experienced team of pre-hospital consultants and professors to provide clinical governance and on-call telephone advice when required. They reviewed and audited activities in depth, discussed clinical effectiveness and shared ideas to improve the service and ensure the critical care team continued to provide best practice and safe patient care. In addition, the pre-hospital care consultants flew with the EHAAT crew regularly to supervise practice and ensure their own competencies, and this included the medical director.

Clinical governance days (CGD) were held monthly. 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 and change. These meetings were chaired by the service's governance leads, medical director or deputy and findings were reported at clinical committee. We reviewed clinical committee minutes from May 2022, these were comprehensive and covered areas of clinical effectiveness, audit, research, education and training.

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 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.

## 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.**

There were established and understood arrangements to identify, understand, monitor and address current and future risks. There was a systematic programme of clinical and internal audit and this was used to monitor quality and identify where action should be taken.

Meeting minutes for the clinical risk and safety committee and CQC committee meetings showed a clear and well-managed meeting that covered a variety of issues and addressed each standing agenda item. Incidents, aviation and facility risks were standing agenda items.

The service had a risk register that staff regularly reviewed and effectively identified the risks to the service. The service used a risk matrix to assess the likelihood and severity of possible risks. Minutes from the clinical risk and safety committee Minutes showed that staff reviewed the risk register and also updated risk scores at these meeting and all risks had clear ownership.

The service had detailed business continuity plans and emergency response plans. Staff knew where to find these policies and knew their role in each of these plans.

## 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 had invested in innovative and best practice information systems and processes. The service used the data to report against a series of internal key performance indicators (KPIs) which it used to monitor targets. This enabled the service to monitor operational activity such as; training compliance, audit results, available shifts covered, number of aircraft stand-downs, aircraft and RRV mobilisation, number of missions per month, serious incidents, duty of candour incidents and operational and clinical complaints.

Senior staff monitored and presented information about the KPIs in the monthly executive summary report, along with a range of information about the months' missions.

Staff could find the data they needed, in easily accessible format 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 their entry, and ID badges provided.

The electronic patient 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 and family liaison team (PFLT), could log onto the records and review the details of patient care and treatment. This meant the PFLT were able to work with patients and relatives post trauma, to discuss what happened, what treatment was provided and why.

The service had up to date data sharing agreements in place with key stake holders in 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 training and compliance with this training was 91%.

The service shared all recorded information about a patient with the receiving hospital at the time of handover to ensure effective care and treatment.

### Engagement

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

The service routinely requested feedback from all patients they transported and left an aftercare card with patients and relatives with the PLFT contact details.

The service gathered patients' views and experiences to shape and improve services. All aspects of the service are centred around the patient, for this reason EHAAT established a patient engagement forum whereby any research project EHAAT embarks on had the patient's perspective represented. The patient and relative's engagement forum provides feedback and opinion in relation to current practice and new innovations.

# Emergency and urgent care

The service encouraged patients and their relatives to visit the base and collected feedback from patients where possible.

The service had developed an online patient feedback form, which patients could access via the service website. In addition, they have recently started to send patient survey questionnaires. At the time of the inspection this was new and so there was limited data for the service to analyse and determine if any improvements could be made.

The service effectively involves over 400 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 service. Community events were organised, including holding a Christmas market. These events included patients being offered the opportunity to speak about their experiences with the service.

Staff encouraged local groups to learn more about the service they provided, and we saw multiple examples of where patients and their families were invited to meet the clinical and aircrews involved in their care at the airbase. The visitor centres at the air bases were open to the public and the local community to visit and learn more about the work of HEMS.

The service website provided a 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 crews.

The service effectively engaged with their local partners. The service held regular meetings with the local NHS ambulance service that they worked alongside. Feedback from this NHS trust was very positive about the way the service had engaged with them and the way the service looked for improvement.

The service collaborated with a local college to produce a bespoke sculpture to be displayed at the two airbases.

The service effectively engaged with their national partners. We looked at records showing that the staff went to national air ambulance conferences to present research posters and share ideas with others.

The service effectively engaged with their international partners. The service had visits to other air ambulance service in another country to have a shared approach to learning across the globe and staff from various countries also come to work with EHAAT as part of their pre-hospital care training.

Managers engaged with their staff and acted based on their feedback. The service completed a staff survey yearly. We reviewed the most recent staff survey. A variety of key findings and a variety of questions that helped the service to understand their staff better. An action plan was put in place to address any of the outcomes of the survey that were unfavourable.

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.

# Emergency and urgent care

## Learning, continuous improvement and innovation

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

There was an embedded and systematic approach to improvement across the organisation. The service was committed to ongoing development, improvement and sustainability.

Service leaders strongly believe high quality research to be crucial for evidence-based practice in the delivery of pre-hospital critical care. As a result, EHAAT recognised the need to create a research lead role to provide the infrastructure, continuity and expertise to facilitate high quality ethical research to inform clinical practice and operational decision-making.

The service's clinical strategy has been underpinned by the establishment of the EHAAT centre for excellence, to deliver high standards of pre-hospital clinical care through research, innovation and education. The centre for excellence will focus on three main areas; head injury, cardiac arrest and patient outcomes and experience.

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

In November 2021 the service developed a virtual lecture series as a tool to encourage shared learning across pre-hospital care providers of all backgrounds. The virtual lectures were themed on pre-hospital care topics and delivered by experts within that field. By delivering the lectures virtually, a wider global audience was able to take part. The series started in November 2021.

To ensure maintenance of competency and currency across a wide range of interventions and individual experience EHAAT developed the critical clinical case passport (CCC passport). The CCC passport was developed in 2019 to encourage critical care doctors and paramedics to maintain validation across a series of key competencies. When initially introduced, the CCC Passport was a pocket-sized document that enabled clinicians to record their latest cases and procedures and maintain validation. In the last year the CCC passport has been incorporated into the electronic governance system, allowing EHAAT's critical care doctors and paramedics to manage their portfolio of cases and procedures and track their progress via their smartphones. The CCC Passport has been adopted by an air ambulance service in another region.

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

EHAAT actively involves in a number of regional and national projects, including collaborations with pre-hospital care networks, Acute NHS hospital trust, NHS ambulance trusts and other HEMS providers.

The service is also involved in a national study to establish research priorities for UK pre-hospital critical care. At the time of our inspection this was under review for publication by peer reviewed scientific journal.

Outstanding ☆

# Emergency and urgent care

The service was participating in a study looking at the impact that a pre-hospital critical care team has on the treatment and management of traumatic brain injuries.

The service was also participating in a national study looking at patient and public involvement, engagement and participation.

As part of their operational strategy, the service has purchased night vision goggles to enable the team from the North Weald base to fly during hours of darkness. Initially this will be until the current shift finish time of 8.30pm. At the time of our inspection training was being rolled out to be fully operational during the hours of darkness by spring 2023.

The service continual looks for ways to reduce or offset its carbon footprint where possible. They have recently replaced two of their rapid response vehicles (RRVs) twin engine hybrid models, offering savings to both the environment and running costs.