

Devon Air Ambulance Trading Company Limited

Devon Air Ambulance Head Office

Inspection report

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Outstanding 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

Our rating of this location improved. We rated it as outstanding because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service had developed training programmes and had provided, in partnership, higher degree opportunities for staff.
- The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe.
- People were protected by strong comprehensive safety systems, and a focus on openness, transparency and learning. A proactive approach to anticipating and managing risks to people who used services was recognised as being the responsibility of all staff. Staff identified and quickly acted upon patients at risk of deterioration. External organisations were actively engaged in assessing and managing anticipated future risks.
- There was a truly holistic approach to assessing, planning and delivering care and treatment to people who used the service. There was a safe use of innovative and pioneering approaches to care. New evidence-based techniques and technologies were used to support the delivery of high-quality care.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued.
- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services.
- People were truly respected and valued as individuals. Feedback from people who use the service and those who were close to them was continually positive about the way staff treat people. People thought that staff went the extra mile and the care they received exceeded their expectations. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- The involvement of other organisations and the local community was integral to how services were planned and ensured services met the needs of local people and the communities served.
- Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Leaders and staff used innovative approaches to gather feedback from people who used services and the public. This was then used to plan and manage services. They collaborated with local, national, international partner organisations to help improve services for patients. There were consistently high levels of constructive engagement with staff, patients, relatives and external stakeholders.
- There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Leaders encouraged innovation and participation in research.

However:

- The thermometer in the medicine's storage room was not in place. This was promptly addressed on the day of inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Outstanding 	This service has not previously been inspected. We rated it as outstanding. Please see overall summary above.



Summary of findings

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Summary of this inspection

Background to Devon Air Ambulance Head Office

Devon Air Ambulance provided air ambulance services for the county of Devon and surrounding areas. Operating out of Eaglescott airfield and Exeter airport, in Devon, Devon Air Ambulance had two helicopters and two critical care cars; the latter operated when poor weather or essential maintenance prevented the aircraft from flying. These vehicles delivered doctors and paramedics to an accident. The website stated “sometimes our paramedics or doctor might be delivered to scene and then travel with a patient to hospital by land ambulance”.

The service had developed and commissioned a helicopter emergency medical service dispatch service, which fielded all referral calls via a triage system, and was hosted by a local NHS Ambulance Trust. The service operated from Exeter between the hours of 7am to 2am each day and from Eaglescott 9am to 7pm, noted as seasonal. The critical care team were available 7am to 7pm.

The annual report for 2021 noted the service undertook 1,384 missions by helicopter, 516 missions using the critical care cars. Total number of missions 1,900 from which 1,050 were reported as trauma missions, 844 medical missions with 1,054 adults, 137 children and 288 persons over 70 being assisted. Conditions treated included 315 cardiac arrests and 274 road traffic incidents.

To June 2022, the patient services internal reporting dashboard reported the service recorded 431 incident reports with 74 near miss events'. No never events were recorded.

The regulated activities carried out at this location were treatment of disease, disorder and injury, diagnostics and screening procedures, transport services, triage and medical advice provided remotely and surgical procedures.

The provider had a registered manager in post at the time of the inspection. The registered manager has been in post since registration in April 2019.

Devon Air Ambulance employed two critical care paramedic manager, two critical care paramedic senior managers and a Lead Critical Care Consultant Doctor, 13 critical care consultants and one junior doctor, eight specialist paramedics in critical care and eight advanced paramedics in critical care. The service also employed a Helicopter Emergency Medical Service Delivery Manager, three patient liaison clinicians, six administrators and two pastoral volunteers.

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 21 June 2022. The service had not been previously inspected.

How we carried out this inspection

The team that inspected the service comprised of a CQC lead inspector, an inspection manager and a specialist advisor with experience in emergency and urgent care. The inspection was overseen by Catherine Campbell Head of Hospital Inspection.

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

Summary of this inspection

We reviewed four employment records, five patient records as well as audit outcomes, governance documents and other policy records kept by the service. We spoke with 10 patients and their families and 13 staff to gain their views. We spoke with two members of the local ambulance trust executive team and the helicopter emergency medical team deployment officer.

What people who use the service say

During our inspection we spoke with 10 patients and their families. Feedback was consistently positive and complimentary about the service and the care and support they received. All patients and families described the service in exceptional terms and said things such as ‘couldn’t have done more’, that the service was quick to respond and that handover to hospital staff and follow up by the service after the patient had been admitted to hospital was ‘very much appreciated’.

Outstanding practice

We found the following outstanding practice:

- The service promoted an open, “Just” culture to reporting all types of incidents. Patients benefited from a culture of learning that responded when things went wrong in order to provide innovative care and treatment.
- Governance systems comprehensively reviewed incidents and use feedback to inform scenario simulation-based training. Post incident staff were supported through the engagement of two volunteer pastoral support workers with a robust framework for staff support and debrief, and an open culture for reporting incidents.
- There were higher degree opportunities for staff and links with local educational establishments which showed commitment to staff development. The leadership proactively encouraged and supported staff to develop their skills and knowledge. The service had adopted an enhanced supervision and appraisal process which had moved away from an annual appraisal to a bespoke, more frequent meeting system.
- The service had conducted research on new methods of treatment and care, new technology, new procedures and were continuing develop and innovate. For example, the service did not carry packed red cells but they did carry lyoplas which is a type of blood plasma that is easier to store longer term and they have established systems to improve reconstituting it for injured patients.
- On commencement of their CQC registration the service appointed a research lead who is currently working on local research that the service had undertaken into the prescribing of rasemic ketamine to reduce the long-term side effects of using normal ketamine and reduce the future potential of post-traumatic stress disorder in trauma patients. We were informed they intend to publish this in a reviewed journal.
- The service had developed a “cold” chain supply of fresh frozen plasma (FFP) supplied by a local NHS trust and delivered by a biker’s charity. The service has worked with the local NHS to ensure that, should national guidance change in the future, the systems in place will be able to adapt accordingly.
- The service engaged with a comprehensive range of partners with the aim of improving its services and the quality of care to all patients. The community liaison work and engagement was extensive and widespread. We saw work undertaken with the local communities to establish 196 community landing sites and the use of technology to ensure they were easily accessible and fit for purpose. The summary of outreach activities for the first quarter of 2022 noted educational work with local communities, joint working with other emergency services, the military, the college of paramedics, universities and local NHS Trusts.
- The patient liaison service was a dedicated in-house team and the service had established links with local and national services so patients could be followed through their hospital journey and post discharge. Evidence suggested there was strong support for carers and relatives. The provider also gave support to witnesses at the scene of an accident, providing contact information should they require post incident help and support.

Summary of this inspection

- The service had strong inspirational leadership that consistently supported people across the service and created a positive patient focused culture. Learning, research and innovation was encouraged at all levels in order to improve patient outcomes, promote patient safety and achieve the services mission.
- The service undertook a “help with your heart survey”, with the public to identify the obstacles in getting members of the public to be willing to step in. From the results of the survey the service planned and delivered five cardiopulmonary resuscitation and defibrillator training days across the area where 242 members of the public attended.
- The staff involvement and consultation at all levels was said by staff to be exceptional, with staff at all levels stating how their work was recognised, valued and they had a say in the running of the organisation.

Areas for improvement











Action the service **SHOULD** take to improve:

- The service should ensure that there is a system in place to record temperatures in relation to medicines storage and that these are monitored to provide assurance that medicines are fit for purpose and stored at their optimal temperatures.

Our findings

Overview of ratings

Our ratings for this location are:

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



Emergency and urgent care

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

Are Emergency and urgent care safe?

Good



This service has not previously been inspected. We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training programme considered current best practice in relation to pre-hospital emergency medicine and patients benefited from the range of life saving training and interventions provided by staff in an emergency. It included a range of modules covering subjects such as, but not limited to, the highest level of life support training, fire safety, manual handling, information governance, infection prevention and control, conflict resolution, safeguarding adults and children and vehicle familiarisation and driving observation. Clinical staff completed training on recognising and responding to patients with a learning disability.

The service had an online training programme and conducted face to face training. Staff spoke positively about training opportunities that had been offered, for example one specialist paramedic told us how they had received training to expand their role and take on more responsibility. Other staff told us leaders actively encouraged and supported them to develop their skills and knowledge. In-house training included relevant scenario-based immersive training to facilitate discussion and learning. The service had developed, in partnership with Plymouth University, the Masters Degree in Pre-hospital critical care transfer and retrieval. The course has been running since 2015 and has been attended by paramedics from across the region.

We reviewed the training records of 49 members of staff and found all staff were fully up to date with their training aside from six who still had some booked modules to complete. Managers monitored mandatory training through an electronic dashboard and alerted staff when they needed to update their training by using a red, amber, green framework. Training compliance is an agenda item on the clinical committee and non-clinical training was a agenda item for the operations committee. All staff and managers had access to a training dashboard to monitor their training requirements and completion. This included emergency response driving and we were informed that this was now at level three, certificate in emergency response ambulance driving standard.

Safeguarding



Emergency and urgent care

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

Staff had training on how to recognise and report abuse and they knew how to apply it. The service had clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. The service had an up to date safeguarding policy with clearly defined roles and responsibilities for staff regarding safeguarding and the safeguarding referral process.

Records showed all staff received level one safeguarding training for adults and children. Level two children safeguarding training was provided for pilots. Advanced paramedics critical care, specialist paramedics critical care and critical care doctors were provided with level 3 safeguarding training. Non-executive directors were provided with level one safeguarding children and adults training and the non-executive director lead for safeguarding has undertaken level 3 training. This was in line with the intercollegiate document *Adult Safeguarding: Roles and Competencies for Health Care Staff 2019*.

The service had a named safeguarding professional and executive safeguarding lead both of whom were provided with level four training in safeguarding children and adults. Mandatory training included domestic violence, equality and diversity, preventing radicalisation, female genital mutilation, child sexual exploitation and bullying and harassment.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the *Equality Act 2010*. Staff we spoke with clearly explained how they placed patients at the centre of the safeguarding process and were clear on their roles and responsibilities.

Staff knew how to make a safeguarding referral, who to inform if they had concerns including how to contact the safeguarding single point of contact to make a safeguarding referral. Staff had experience and training in meeting the needs of patients who may lack capacity and who may need additional support to consent to their treatment to keep them safe. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

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, helicopters and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning records for both air bases and these included records of vehicles and equipment. Vehicles were inspected and appeared clean. Staff cleaned the vehicle and equipment after use, which was in line with guidelines.

Staff carried out swab tests on every vehicle and vehicles were deep cleaned at least once every four weeks. There was a system in place to monitor vehicles due a four weekly clean and any safety checks required. The air ambulances were cleaned in line with strict aviation protocols and policies, pilots had overall responsibility for ensuring that the air ambulance was ready for any mission and the clinical team are responsible for ensuring that it is 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



Emergency and urgent care

board. Cleaning records were seen for Eaglescott and Exeter bases, together with cleaning records for the Air Ambulances and the critical care cars. Infection control audit seen had included checks that staff wore the appropriate uniforms, and were compliant with hand hygiene practice. Staff seen were bare below elbow. *NICE guideline QS61 Statement 3 (2014), Infection prevention and control – Hand decontamination.*

Staff followed IPC including the use of personal protective equipment (PPE). Staff we spoke with had a comprehensive knowledge of the services IPC processes. The services IPC policy was up to date, and reflected current guidance in relation to infection control, including COVID-19. Staff had access to a wide range of personal protective equipment, handwashing facilities, sanitizers and antibacterial wipes. Hand sanitisers were readily available throughout the location, and staff told us they used them before and after every episode of direct patient contact or care. This was in line with *NICE guideline QS61 Statement 3 (2014), Infection prevention and control - Hand decontamination.*

The service performed well for cleanliness. We looked at cleaning logs of the services base and vehicles, staff had fully completed these and the location was visibly clean when we visited. We saw evidence an infection control audit was carried out on 16 May 2022 for the Eaglescott airbase. This was scored at 97%. It was noted on the audit that a new waste bin was needed as the current one did not lock, this had been reported to facilities management for action. We reviewed an infection control audit for Exeter airbase which was undertaken on 18 June 2022. This was scored at 100%.

We reviewed minutes from the clinical committee meeting held in June 2022. We saw infection control was an agenda item and COVID-19 precautions were discussed.

The medical storeroom in the airbase had a lack of hand gel for non-carriers, and no visual reminder to anyone on entry. This was promptly addressed at time of visit.

Environment and equipment

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

The 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 observed to be stored with a secure area. Visitors were escorted while on site. The design of the environment followed national guidance. Staff carried out daily safety checks of all specialist equipment. Including vehicle's, helicopters and resuscitation equipment. Checks such as portable appliance testing were carried out through the facilities department, and records showed this was monitored. During the inspection we saw pre-flight checks taking place which appeared comprehensive.

Staff disposed of clinical waste safely. Staff followed the services IPC policy in relation to clinical waste, we noted that staff stored clinical waste safely, including sharps.

Assessing and responding to patient risk

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



Emergency and urgent care

People were protected by strong comprehensive safety systems, and a focus on openness, transparency and learning. A proactive approach to anticipating and managing risks to people who used services was recognised as being the responsibility of all staff. Staff identified and quickly acted upon patients at risk of deterioration. External organisations were actively engaged in assessing and managing anticipated future risks.

A proactive approach to anticipating and managing risks to people who use services was embedded and is recognised as the responsibility of all staff. The service provided pre-hospital emergency care to patients and due to the emergency service, they provided, staff could not carry out individual risk assessments for patients until they arrived on scene.

The service 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 hemorrhage, or head injury, amongst others, all based on best current practice models.

The service ran a specialist dispatch team triage service for the helicopter emergency medical service. This was hosted by a local NHS Ambulance Trust. Calls and referrals were triaged, and risk assessed using the services' standard operating procedures. The service utilised a recognised Major Trauma Triage Tool to ensure patients were transported to the most appropriate hospital for treatment.

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.

Staff used nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff told us how they monitored vital observations continuously so they could quickly detect the deteriorating patient. Monitoring devices produced a graph that clearly showed the observations and any deterioration. This monitoring was constant and removed the risk of missing significant observations during intervals. The service had a process which allowed a consultant either on call or at the location to provide clinical advice by telephone and give guidance on the patient's condition. Staff used this process to get additional clinical advice when on scene and during patient transit. Staff told us the support by consultants was effective and made a positive contribution to the patients care.

There was a safe and effective escalation process for deteriorating patients or situations that were beyond the abilities of staff. Additional resources could request by the Helicopter Emergency Medical Service (HEMS) desk which was located alongside the NHS ambulance trust critical care desk. The helicopter emergency medical service 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 requested if the number of patients was too high for a single HEMS team to manage safely.

Staff used the pre-hospital emergency anesthesia (PHEA) clinical guideline and the national ambulance quality indicators for people experiencing an out of hospital cardiac arrest. Audits were overseen by the services Quality improvement, research and audit team, and the audit of the 2021 PHEA activity was reported to the clinical committee in May 2022 as been completed and awaiting clinical review. A dashboard provided monthly data on the services performance against the Ambulance Quality Indicators and the use of the pre-Hospital emergency anesthesia (PHEA) clinical guideline.



Emergency and urgent care

We reviewed five sets of patient's notes and all risk assessments were accurate, legible and observations clearly showing the timely assessment of risk. All risk assessments were reviewed at post incident meetings and at the monthly governance meetings to identify any learning, good practice or concerns. There was evidence of notes being used in debrief meetings with lessons learnt.

Staff were able to discuss risk effectively with people using the service. People who use services and those close to them were actively involved in managing their own risks, supported by the providers Patient Liaison Clinicians.

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 bank, agency and locum staff a full induction.

Managers accurately calculated and reviewed the number and grade of medical and paramedic staff needed for each shift in accordance with national guidance. The service had enough staff to keep patients safe and managers accurately calculated and reviewed the number and grade of staff in accordance with national guidance. They had enough paramedics, doctors and pilots to cover shifts. Handovers between shifts were structured in a way that ensured there was no break in cover. The service had adopted an alert system by text and email which notified staff prior to commencement on shift that they should check the services electronic database system for critical information they need to know before deploying.

We reviewed staffing rotas for medical and paramedic staffing for the three-month period, 22 March 2022 to 21 June 2022, showing full cover. The service produced a chart that detailed present staffing and future planning. We saw that staffing was monitored by leaders via their governance processes and challenges in the recruiting of pilots, which were being addressed.

Staff were encouraged to visit other bases to gain knowledge and experience.

The service also employs Patient Liaison Clinicians to provide support for patients, family and anyone affected by the incident, also Pastoral Support Volunteers to provide support to staff.

Records

People were able to transition seamlessly between services because there was advance planning and information sharing between teams. Innovative practice supported accurate and personalised information sharing.

The electronic record system enabled staff to manage and share the information that was needed to deliver effective care treatment and support, and was coordinated to provide real-time information across services, and support care for people who use services. Appropriate staff from across the organisation, including the patient and family support team, could log onto the records and review the details of patient care and treatment. This meant the patient and family support team were able to work with patients and relatives post trauma, to discuss what happened, what treatment was provided and why. The service had information sharing arrangements with other health care providers and a named professional to ensure that information met the Information Commissioner's Office (ICO) information requirements relating to public interest, promoting openness by public bodies and data privacy for individuals



Emergency and urgent care

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

Five sets of records were reviewed and found to be up to date, stored securely and easily available, and demonstrated staff had completed them clearly with medicines and interventions recorded. Patient records were completed on scene in writing, then transferred to an electronic system.

This system allowed for the easy upload, display of patient information and audit of activity. The system had an easy use interface for learning and follow up. These were emailed to local hospitals using a secure portal with the NHS.

Medicines

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

Compliance with medicines policy and procedure was routinely monitored and action plans were always implemented promptly.

Staff stored and managed all medicines and prescribing documents safely. No medicines were stored at the location however, there was a locked cupboard should medicines need to be stored before going to the airbases. At the Exeter airbase there was a medical storeroom that contained controlled drugs and other clinical consumables. We checked 12 consumables and all were in date. Midazolam, Diazepam and Ketamine stock records were checked and found to be in order. The service has a controlled drug officer and a controlled drug policy.

We reviewed medication audits from the last three months for the Exeter and Eaglescott airbases. The latest audits were for May 2022. Exeter scored 98.9 with a comment about a missing signature. Eaglescott, for the same period scored, 98.3 with a comment about a mistake being written over.

Staff learned from safety alerts and incidents to improve practice. The service was undertaking research into the prescribing of a specific type of drug, ketamine, to reduce long-term side effects and reduce the potential of post-traumatic stress disorder in trauma patients. This was undertaken following staff feedback on the effects of the drug on patients.

Daily Fridge temperatures checks are part of the airbase daily check list , records were completed daily.

The thermometer in the medicine's storage room was not in place and had fallen behind a cupboard. This was addressed at time of visit. We were told the thermometer was a back-up as the design of the room was such that the temperature would remain constant.

We were informed that a visual daily check is made of the storeroom thermometer to ascertain whether the room had exceeded 25 degrees, but these readings are not recorded, and daily results are not monitored for governance assurance purposes. We were told, that should it be observed that the temperature had risen above 25 degrees then an adverse incident would be reported. The medicines room was built of brick with no windows and radiators that were set at frost protection, the manager informed us that a previous temperature audit had found that the temperature in the room had not risen above 25 degrees.



Emergency and urgent care

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. We reviewed the service's incident reporting policy that was up-to-date and had a date to be reviewed. Staff we spoke with told us they knew how to report incidents on the service's cloud based management system which was accessible from computers at the location or by mobile phones while out of the office at scenes.

All staff we spoke with were open and transparent, and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of quality. Staff understood and could explain duty of candour and were able to give examples of how they would apply this.

Staff reported serious incidents clearly and in line with the service policy. We reviewed three incident reports on site during our inspection which showed staff raised concerns and reported incidents and near misses in line with the services incident reporting policy. We saw evidence of the results of these being feedback to staff to discuss lessons learnt.

Staff told us that they worked within and were supported by an "Incident learning culture", not an incident reporting culture, due to the nature of the incident reporting process and a culture where incident reporting was positively encouraged by the service. The provider had a sustained track record of safety and used accurate performance information to consistently improve its services and make progress towards safety goals reflected in a zero-harm culture. Innovation is encouraged to achieve sustained improvements in safety and continual reductions in harm.

Learning was based on a thorough analysis and investigation of things that went 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.

All reports were entered into an electronic system which produced a dashboard that could be accessed by all staff. These were investigated by the governance lead who reported to the governance monthly meeting. An example was provided of a case where information was missed in the triage phase of an incident. This was due to be reviewed at the next meeting.

Debrief and learning sessions were held twice a week for staff where incidents were discussed and learning points were identified. The outcomes of these meetings were distributed to all staff and included in the services governance and operational meetings.

The service had reported no never events. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations are available at a national level and should have been implemented by the service.

Are Emergency and urgent care effective?



Emergency and urgent care



This service had not previously been inspected. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

There was a truly holistic approach to assessing, planning and delivering care and treatment to people who used the service. There was a safe use of innovative and pioneering approaches to care. New evidence-based techniques and technologies were used to support the delivery of high-quality care

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

Staff we spoke with explained how they worked to service guidelines and we reviewed 26 of the service's standard operating procedures, all of which were in date, had a date for review, a procedure owner and referenced to current best practice in pre-hospital emergency medicine (PHEM). The service used and participated in research in order to not only meet good practice standards in relation to national guidance, but to contribute to research and development of national guidance and share this with other PHEM services across the region.

The service led on the National HEMS (Helicopter Emergency Medical Service) Research and Audit Forum, which provided benchmarks for providers, and developed national quality standards and policies.

The Cardiac Arrest Annual Audit, Pre-Hospital Emergency Anaesthesia audit, and the Ambulance Quality Indicators monthly audits show the service consistently exceeds expected national targets.

Care was regularly monitored to ensure it was in line with evidence based, guidance, standards and best practice. Each time a patient record was completed, this was reviewed by the consultant of the day, the clinical governance lead doctor or the clinical manager, to ensure staff provided care and treatment based on current national guidance and evidence-based practice.

Twice a week the service arranged meetings of team members to discussion cases that had occurred in the previous week. These meetings were chaired by a consultant and would identify lessons to be learnt, and the findings of these meetings would then be disseminated to all staff.

All clinical operations are reviewed by the Governance lead Consultant Doctor to identify learning points. Complex cases are chosen to present at the monthly governance meetings.



Emergency and urgent care

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

The service was assured new and existing staff had read and understood policies and procedures. On induction, the service sent out all standard operating procedures and policies to new staff. Policies and procedures were shared on the services cloud based management system, and the service tracked who had or had not read a policy or an update. Data on staff compliance with updates was collated by managers and scrutinised by the services clinical governance committee to ensure all staff were aware of and using up to date guidance

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. Review of patient records showed staff made an assessment of pain relief needs and altered medication to suit the needs of the patient. Staff would look at the least invasive pain relief as a first option, especially with children, who were often very frightened in an emergency and needed a great deal of reassurance

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

Patients received pain relief soon after it was identified they needed it or they requested it and staff prescribed, administered and recorded pain relief accurately. We reviewed five patient records which showed comprehensive recording of pain relief and effective handover to admitting hospitals. Pain management audits were carried out and an example was seen of how practice had been changed in relation to the amount of stock carried as a result of learning from an incident.

Patient outcomes

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

There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Leaders encouraged innovation and participation in research.

The service was a member of the Air Ambulances UK for which it is supporting on quality standards development and was a member of the Peninsula Trauma Network.

The service participated in relevant national clinical audits. Staff we spoke with were proud to participate in audit, and viewed this an opportunity to further improve services, build on their own skills, knowledge and competencies whilst improving outcomes for patients.



Emergency and urgent care

The service collected data for submission to national audits for heart attack, stroke, sepsis and cardiac arrest. These were sent to the local ambulance trust where they are merged and sent on to the national database. Data from audit outcomes was shared across the service, and with external stakeholders. Data reviewed found that the service consistently, over the period seen, met or exceeded the ambulance services national average Ambulance Quality Indicators.

We saw the cardiac arrest annual audit for 2019, the Ambulance Quality Indicators for May 2022, the Pre-Hospital Emergency Anaesthesia (PHEA) annual audit for 2019, review of intubation success rates November 2019, audit of response times June 2021 to May 2022.

Devon Air Ambulance Trading Company Limited employed three members of staff to act as a patient liaison, who contacted the hospital and patients to monitor the outcomes for these patients which were then loaded onto the service database. We saw the May 2022 Ambulance Quality Indicators (AQI's) dashboard, that was updated monthly and provided information on cardiac arrest, return of spontaneous circulation (ROSC), an ST segment elevation myocardial infarction (STEMI), stroke cases, sepsis cases and pre hospital emergency anaesthesia (PHEA).

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. These audits included, PHEA, cardiac arrest, review of pre-hospital deaths and clinical record completion. Audits were undertaken annually with response times, pain management and time on scene audits undertaken three yearly. Managers used information from the audits to improve care and treatment and we saw evidence of this.

Managers shared and made sure staff understood information from the audits. Cases were discussed at the monthly clinical governance day and patients were identified for the research study into the use of racemic ketamine for pain relief. Audit data was scrutinised by front line staff, managers, the clinical governance team and governance processes; quality indicators from audit were routinely reviewed.

The service had adopted the Somerset and North Devon regional vascular network, local emergency department bypass policy. A mechanical thrombectomy, a type of surgery to remove a blood clot in a vein or artery, retrieval standard operating procedure, agreed with the local regional centre, was in place.

The service had found patients who had received ketamine for pain relief would often report strange sensory experiences post administration. The service, in response to this, was running a clinical research programme to assess the impact of prescribing of racemic ketamine to reduce the long-term side effects of using this drug and its impact on reducing the future potential of post-traumatic stress disorder in trauma patients.

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 the care had been effective, and what impact the care and treatment had on the patients longer term outcomes. The service participated in local and national audit and research to assess the effectiveness of care given on scene and how that care influenced patient outcomes, shared this with other hospital emergency services to make improvements in the service.

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

Competent Staff



Emergency and urgent care

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

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

Managers gave all new staff a full induction tailored to their role before they started work. The service's up to date recruitment policy clearly set out roles and responsibilities in ensuring staff and volunteers had been inducted to the service and had the right information and recruitment checks completed to carry out their roles safely. We reviewed the induction records of three new starters. A structured and comprehensive induction checklist was in place, and we saw evidence of these being completed. We spoke with staff who confirmed they had received a comprehensive induction on starting with the company and were receiving ongoing training and supervision.

The service regularly updates its policies and processes for using volunteers and innovative practice, and the use of volunteers helps to measurably improve outcomes for people. Volunteers are used to maintain the community landing sites to allow greater access for air ambulance services to incidents. A summary of outreach activities from January 2022 to May 2022 reports that the service spent 450 hours engaging with a range of supporters, facilitating five community CPR and defibrillation training sessions for over 240 members of the local community.

Managers supported staff to develop through constructive appraisals of their work. The service used an electronic dashboard to monitor and plan supervision and appraisal. The appraisal system had moved from a yearly meeting to a bespoke, more regular system covering health and wellbeing, workload, people / team / relationship update, role specific, learning and development, risks, priorities, new and amended policies and procedures. Five staff were identified as supervisors, these were the lead consultant, clinical Manager, clinical governance doctor, operations manager and the previous clinical governance doctor who was taking up a new role in training and education for the service.

Support staff and managers met with their line managers every four weeks, paramedics received supervision every four to six weeks and doctors received supervision every 12 weeks. An audit of supervision dated June 2022 showed no outstanding sessions and 100% compliance.

Practical training and revalidation records were seen for seven staff which showed training over a range of subjects relevant to their roles. The database held information on supervised shifts and recorded the time lapse between them.

The service liaised with the local ambulance trust and had established a helicopter emergency medical service (HEMS) dispatch team. This involved the helicopter emergency medical service deployment officer overseeing the training, appraisals and supervisions of the HEMS staff. The service had mutual training with the local ambulance trust, and we were informed the local ambulance trust would request welfare checks on Devon air ambulance staff when they had been in a difficult incident and vice-versa.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.



Emergency and urgent care

Managers made sure staff received any specialist training for their role. The service had a partnership with a local University since 2016 to provide a post graduate certificate, post graduate diploma and masters degree in pre hospital critical care retrieval and transfer.

Managers recruited, trained and supported volunteers to support patients in the service. The service employs two pastoral volunteers to provide counselling support to the crews.

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

Multidisciplinary working

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

The service had a service level operating agreement with the local ambulance trust. We were told by their executive members there had been a "minimal amount of missed calls and no complaints". We were shown evidence of regular meetings between the service and the local ambulance trust representative to discuss operational areas. Improvement is checked and monitored.

Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who use services.

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. These included monthly clinical governance days where staff would present cases and lessons learnt and other stakeholders, such as the local ambulance trust would be invited to attend and participate in the open session part of the day.

Staff described a truly holistic multiapproach to assessing, planning and delivering care and treatment to all people who used services. Staff proactively worked together to identify and minimise risks to patients and they had used research and innovation as a team to improve patient outcomes.

Staff worked across health care disciplines and with other agencies when required to care for patients, and described positive working relationships. Due to the nature of pre-hospital emergency medicine, the service team worked with a wide range of other professional staff including the police, ambulance staff, hospital staff and after care services. We spoke with the helicopter emergency medical service (HEMS) delivery manager who described how they were involved in working with the local ambulance trust to enhance this service provision and increase the number of staff qualified to support HEMS and critical care operations, which also involved four other charities.

We were given an example of how HEMS teams worked in a multi-disciplinary way in the dispatch procedure. Three forms of dispatch protocols had been established with the local ambulance trust. Auto dispatch, when certain calls from an approved list trigger an air ambulance, immediate dispatch, when response to a call is based on the training and experience of the dispatcher. This is based firstly on therapeutic need, followed by organisational factors and the third known as interrogated dispatch where the HEMS dispatcher will ring the caller for more information.

When the air crew commence duty, they contact HEMS dispatcher to advise on flying conditions, any other factors that could affect response times and capability.



Emergency and urgent care

Staff worked together and agreed plans to transport the patient. Before transporting the patient, the staff communicated with the other teams to discuss the best method of extraction. The teams assigned roles and tasked clinicians to retrieve appropriate equipment. Staff would communicate where the patient would be transported to, the method of transport and then confirmed that all involved were happy with that decision before making the extraction.

Seven-day services

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

The provider was not offering a 24-hour service, however the service was working towards and there were plans for developing this in the future. The service operated from Exeter airport from 7 am to 2 am each day and Eaglescott base, based on seasonal demand, from 9 am to 7 pm each day. The critical care team was available from 7am to 7pm each day. We were shown the plans for the development and the service impact assessment on disruption to existing services during the change process.

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 the impact on patients' liberty.

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. All staff had a good understanding of the Mental Capacity Act and acted in the patient's best interests if they were unable to consent. Records showed staff had completed training on the mental capacity act and dementia, as well as safeguarding to ensure they understood the needs of people who may become more vulnerable due to the nature of the emergency they were in.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with told us they would help patients to involve them in decision making and support them by explaining complex medical information in simpler ways, using note pads, hand gestures or interpreter services where necessary. Often staff could rely on relatives at a scene for additional support and information regarding the patient's condition, to see if the patient was living with dementia or other mental health issues prior to the emergency taking place. The staff understood fluctuating capacity and the need for immediate sedation if a patient was delirious or could cause additional harm to themselves or others if they weren't immobilised on scene. The service had up to date medicines policies in place, including the least restrictive methods for restraining a patient through sedation.

Staff made sure patients consented to treatment based on all the information available and records we reviewed showed staff clearly recorded patient consent in the patients' records. Managers reviewed and monitored practices and records around consent to improve how people were involved in making decisions about their care and treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, 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.



Emergency and urgent care

Are Emergency and urgent care caring?

Outstanding



The service had not previously been inspected. We rated it as outstanding.

Compassionate care

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

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. During our inspection when speaking with staff, volunteers, patients and relatives we observed a strong, visible person-centred culture. Staff we spoke with were highly motivated and inspired to offer care that was kind and promoted people's dignity.

Feedback from people who use the service, those who are close to them and stakeholders is continually positive about the way staff treat people. People think that staff go the extra mile and their care and support exceeds their expectations. We were told staff "couldn't have done any more". We reviewed a selection of recent patient feedback and in addition patients told us they were most impressed by the follow-up service and the support they received. Time to scene was described as very quick and pain relief was administered quickly with the crews described as "calm and collected", "professional", and "couldn't have cared any more".

Patients reported the crew continued to be caring and supportive after arrival at the emergency department. A card with details of the service was given to everyone who had been on the scene of any incident to enable them to ask any questions they may have or, if they required support, how to contact the service.

Staff told us how they would speak with relatives on scene or bystanders who may have witnessed the incident in order to fully ensure that the patient needs were met. Staff are highly motivated and inspired to offer care that is kind and promotes people's dignity.

Patients were followed through the admission process, inpatient stay, discharge and post discharge by the liaison team. At the earliest opportunity patients were given details of the team treating them, treatment that had been provided and possible effects and where appropriate the patient and family were provided with information on support groups and charities to provide on going support.

Emotional support

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



Emergency and urgent care

Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Staff recognised and respected the totality of people's needs.

Staff recognise and respect the totality of people's needs. They always take people's personal, cultural, social and religious needs into account, and find innovative ways to meet them.

People's emotional and social needs are seen as being as important as their physical needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We spoke with the patient liaison clinician (PLC) who told us they received all the information about incidents of the previous week and assessed the impact on patients and families.

The PLC had a team of three staff who were allocated groups of patients to contact. The patient, family and hospital were all contacted to ascertain what support could be offered to the patient and family. This included a meeting where possible, or phoning the patient or family, to give an opportunity to ask questions about the care they had received. While the staff would not discuss the patients current care they would assist in helping the patient find answers to any questions they may have.

Where there had been a bereavement one member of staff was allocated to act as liaison with the family to provide support and answer any questions, and the service would send a bereavement card.

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 talked to patients in a way they could understand, using communication aids where necessary. Staff explained that in the many cases patients may not be able to communicate due to the nature of their condition, but staff explained the importance of still communicating with the patient as if they were conscious and explaining everything they were going to do to them. If patients were conscious, staff did have small note pads they could use to write details on, draw pictures to explain or ask patients to write details down if they were able.

Staff recognise that people need to have access to, and links with, their advocacy and support networks in the community and they support people to do this. They ensure that people's communication needs are understood, seek best practice and learn from it.

People who use services and those close to them are active partners in their care. Staff are fully committed to working in partnership with people and making this a reality for each person. Staff always empower people who use the service to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs are always reflected in how care is delivered.

A card was given to the patient and family that provided a list of some of the specialist agencies and charities that the patient and families could be put in touch with by the service and a patient guide which included the complaints policy, details of advocacy organisations, safeguarding, equality and diversity principles and details of the service.



Emergency and urgent care

The service had established links with other agencies to support patients, including the police, a road safety charity, and a firm of solicitors to advise the patient on any legal questions they may have. We were told the service have signposted patients to 18 different charities in the past year to ensure the patient received ongoing help and support.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients received an information pack which included a letter of introduction to the patient liaison clinicians, an outline of the service and provided contact numbers and a QR code, a machine readable code that can be scanned by a mobile phone and gives the details of the service website, is available enable patient feedback. Alternatively, the website also provided details to give feedback.

The services website provides public information on the operations of the service, updates on the service and a means of contact.

Are Emergency and urgent care responsive?

Outstanding



The service had not previously been inspected. We rated it as outstanding.

Service delivery to meet the needs of local people

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

The involvement of other organisations and the local community was integral to how services were planned and ensured services met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. The service collected detailed information on all missions and could identify areas of most demand and had planned the position of bases accordingly.

People's individual needs and preferences were central to the delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The services were flexible, provided informed choice and ensured continuity of care.

The service had identified and constructed 196 community landing sites. We were informed that these all had navigation lighting, controlled by a phone call, a google map was provided to the local ambulance service with entrance to the field clearly mapped. The local residents were involved in the upkeep of the field and informed the service if they become unavailable. When these fields were used a member of staff from the service visited the residents to explain why it was used and to assess whether any damage had been caused due to the landing of the helicopter to any property or possessions of the public.

Facilities and premises were appropriate for the services being delivered. A visit to Exeter Airfield found the premises were clean, had appropriate and sufficient equipment and air ambulance patient and flight safety checks were observed being carried out.



Emergency and urgent care

Following a survey of the local community in relation to the willingness to intervene in incidents, a “help with your heart” campaign was launched with five community cardiopulmonary resuscitation (CPR) and defibrillation sessions delivered by the services paramedics. Two hundred and forty members of the community had been trained to deliver CPR and defibrillation in an emergency.

Meeting people’s individual needs

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

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. Due to the nature of the service, a large proportion of patients had reduced levels of consciousness due to illness or injury on scene therefore verbal communication was challenging for staff. Where possible staff used family members or friends to provide the initial translation at the scene. Interpretation services were available for staff in the treatment of patients whose first language was not English. The service had information leaflets available in languages spoken by the patients and local community. The service has a service level agreement with the local NHS Trust for the use of language line, a telephone translation service and all service resource phones and tablets have a voice translator app loaded for immediate access to translation.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The allocation of a patient liaison clinician was arranged for the patient and their family ensured that individual needs were met.

Access and flow

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

Managers monitored response times and made sure patients could access emergency services when needed and received appropriate treatment. People had access to the helicopter emergency medical service (HEMS) service. The service operated from Exeter between the hours of 7am to 2am each day and from Eaglescott 9am to 7pm, noted as seasonal. The critical care team were available 7am to 7pm seven days a week.

Access to the service was by 999 call which would be transferred to the Helicopter Emergency Medical Service (HEMS) operator.

Managers monitored patient transfers, followed national standards and staff supported patients when they were referred or transferred between services. The service had issued a patient services clinical notice which stated due to the patient possibly having had administered medications that the emergency staff may not necessarily be familiar with, the service would continue to maintain clinical responsibility until the risk was mitigated.

The service monitored performance against targets for response times, adjusted elements beyond the air crews control, and the performance time of the deployment of their critical care car.



Emergency and urgent care

The service audited dispatch times (999 call to HEMS dispatch) and launch times (HEMS dispatch to launch) monthly using its key performance indicator dashboard. They also tracked launch times separately for day missions (the target was to be within five minutes)

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.

Results for the period 1 June 2021 to 31 May 2022 indicated that the helicopters had 1,314 missions with the critical care car having 501 jobs. The helicopter figures show that from allocation to mobile had a average time of seven minutes, and from scene to hospital arrival 25 minutes. The figures for deployment of the critical care car showed the following; from allocation to mobile three minutes, from mobile to at scene average 21 minutes and from scene to hospital arrival average 29 minutes and median 25. This was shown to be consistently lower than the April and May 2022 national ambulance quality indicators (better)

Learning from Complaints

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

Patients and relatives knew how to complain or raise concerns. The service had an up to date complaints policy which was available on the services web site. The staff could also leave calling cards at a scene with the details of the services Patient and Family Support team in case anyone would wish to make a complaint.

Details of the complaints and advocacy process were also detailed in the patient guide and patients and their families were allocated a patient liaison clinician to provide information and support.

Records showed that senior managers had received training in complaints management as part of their mandatory training.

The service investigated complaints and identified themes. We reviewed a complaint that had been investigated. The documents included correspondence with the complainant, a comprehensive timeline of the investigation, and the complaint investigation report.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were an agenda item at the clinical governance committee meeting and staff we spoke with confirmed that minutes were circulated and lessons learned discussed.

Staff could give examples of how they used patient feedback to improve daily practice. We were shown an example where, as a result of learning from a patient complaint regarding the administration of sufficient pain relief, it had been identified that time spent on site could be a factor so further equipment was purchased to manage the patients comfort on site for longer periods if required.

A complaints log was seen, there had been two complaints since May 2020. Both complaints had been resolved and we reviewed evidence of communication with the complainant.



Emergency and urgent care

Are Emergency and urgent care well-led?

Outstanding



The service had not previously been inspected. 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 supported staff to develop their skills and take on more senior roles.

Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed. Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The service had a comprehensive leadership structure, with clearly defined roles and responsibilities at all levels. The chief executive officer (CEO) who also had the role of nominated individual, led the service and reported to a board of directors.

The service had promoted internally to the dual role of Operations Director and Registered Manager. All staff we spoke with told us the post holder was very visible, highly committed to the services aims and mission, extremely experienced in hospital emergency medical services (HEMS), approachable to all and that they had spent time with people in all roles across the service in order to understand their needs and promote the services mission.

Leaders had the skills and abilities to run the service. The CEO led a highly experienced and established team including the operations director / registered manager, medical director, clinical manager, HEMS delivery manager, operations manager. Other members of the senior team were the clinical governance lead, The registered manager and nominated individual were highly experienced and qualified within their roles. They understood the importance of health care regulation within their day-to-day leadership roles and its importance in maintaining patient's safety, innovation and positive outcomes.

During our inspection we observed compassionate, inclusive and effective leadership at all levels. The service has adopted an open plan office with the registered manager sitting with the staff.

They supported staff to develop their skills and take on more senior roles. Staff spoken with gave example of career progression and support to take on projects, such as development of the patient liaison service and community liaison service,

There was clear and visible leadership at the service with all staff spoken with reporting that senior staff were approachable and there were no barriers to communication.

Leaders at all levels demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care. The service invested in the development of leadership roles across the service, including succession



Emergency and urgent care

planning to create new roles and respond to increased demands within the service. There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and a leadership strategy and development programme, which included succession planning. We spoke with all grades of staff who stated that they had undertaken training and refresher training for their roles.

The service had a comprehensive business continuity plan and a risk register. Staff spoken to described the leaders having an inspiring shared purpose and strived to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff, including those with protected characteristics under the Equality Act. There was a strong organisational commitment and effective action taken towards ensuring that there was equality and inclusion across the workforce.

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.

There was a clear vision and a set of values including quality and sustainability. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. Staff we spoke with knew and understood what the vision, values and strategy were, and their role in achieving them. Induction records showed the inclusion of training on the company's vision and values in the induction process.

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.

All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and research were proactively pursued.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. All staff spoken with stated they felt valued, supported and listened to, that the management was approachable and they were included in the decision making of the service.

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.

Staff were positive and proud to work in the organisation as evidenced in the best company's survey and the responses from all the staff that we spoke with. The culture was centred on the needs and experience of people who used services with the service seeking to use the views and experiences of the patients. Culture induction days were provided by the company for all staff to attend and was included in the induction timetable.



Emergency and urgent care

In 2021 the service was awarded “outstanding” by best companies ltd, an employee engagement specialist company who had undertaken a survey of the workforce between October and November 2019. The survey was not repeated in 2020 and 2021 due to the COVID-19 pandemic. Eighty three percent of staff responded, 81% of staff agreed the organisation was run on strong values and principles, 93% of staff responded they were proud to work for the organisation and 76% of staff stated the experience they gained from the job would be valuable in the future. One hundred percent of staff reported they had confidence in the leadership skills of the senior management team and the senior managers lived the values of the organisation.

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

Actions taken to address behaviour and performance was consistent with the vision and values, regardless of seniority and the move away from annual appraisal to a form of continuous appraisal had increased the support and development opportunities available to the staff.

Equality and diversity were promoted within and beyond the organisation. Mandatory training records showed that all 32 staff who had been allocated equality and diversity training had completed the module. Staff, including those with protected characteristics under the Equality Act 2010, felt they were treated equitably. Staff welfare was a standing agenda item on the operations committee monthly meetings

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. Mandatory training records showed out of 40 staff identified for whistleblowing training, 37 staff had completed the module. The provider did not have a freedom to speak up guardian, but they had a similar scheme where staff could raise concerns.

The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff we spoke with understood the importance of raising concerns and felt they would be listened to by the senior management. The service had a duty of candour policy and understood the importance of being honest when things didn't go as planned.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively. The service had an embedded method of raising concerns and staff told us they felt comfortable in doing this. Staff and managers spoke passionately about the service, about patient care and how they felt valued by the team and wider management.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. Governance arrangements were proactively reviewed and reflected best practice. The service had a systematic approach to working with other organisations to improve patient outcomes and staff saw the opportunity of working with other organisations as key to improving services. There were clear lines of accountability for governance.



Emergency and urgent care

All levels of governance and management functioned effectively and interacted with each other. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

The clinical governance lead was a consultant in critical care. We were told they had responsibility for the day to day clinical governance of the organisation and oversight of the governance structure.

There were twice weekly team discussions to present cases that had occurred in the previous week. These were chaired by a doctor and were referred to as a “cold debrief”. Two incidents were usually discussed.

Every month there was a clinical governance day, which encouraged open discussion. Actions arising from these meetings were disseminated to staff through the electronic system. Every month included review of the previous month’s questions.

The service also undertook a helicopter emergency medical service-based review of incidents that have included medical interventions, such as use of medications. The clinical governance lead consultant doctor reviewed all clinical operations, looking for learning points. Where complex calls are identified, such as multi agency response these were allocated to a clinician who was given the task of preparing a presentation for the clinical governance group on actions and lessons learnt.

Following its discussion at the clinical governance day it would then be presented at the meeting of the peninsular trauma network, which met monthly, to disseminate the learning across agencies.

Ten other cases were chosen for presentation in the afternoon of the governance day. This session, for staff only, with the morning session open to other agencies to attend.

The clinical governance lead also had the responsibility of overseeing investigations and the service had introduced a “to celebrate form” which was used to thank an individual for their contribution to incident management. This had also been awarded to staff outside the organisation.

The governance day also included a journal club, with each staff member taking it in turns to review a journal article that they had chosen and presented a summary to the meeting. Educational speakers were also invited. The minutes of the clinical governance day in May 2022 reported on a presentation from the Southwest Peninsula Mechanical Thrombectomy Service for Stroke.

There were monthly clinical meetings which reviewed the risk register and were timed to be held a week before governance, to discuss incident investigations and a weekly management catch up meeting to discuss items such as training or complaints. Minutes were not taken for catch up meetings, but minutes were taken and reviewed for the monthly governance and operational meetings.

The service had a quality improvement research and audit team to support the operational crew. We viewed presentation by the team on its function, objectives, the use of the five why’s and SMART (Specific, measurable, achievable, realistic and time-related) objectives, used in the setting of goals and objectives. The service used a business intelligence tool, to create dashboards which provided a monthly update on quality indicator performance



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and daily updates on activity. We were shown the dashboard during the inspection which monitored response times, , intubations, cardiac arrests, sepsis, stroke, pre hospital emergency anaesthesia, STEMI, (ST segment elevation myocardial infarction) and post ROSC (return of spontaneous circulation) This is accessed by all staff and discussed with the team.

The research committee met on a quarterly basis to discuss actions and objectives. The dashboards containing all information were available across all three sites and could be accessed by all staff.

The service held a discussion and debrief on the activities of the patient liaison service twice a week, when outcomes were discussed, and patient and family feedback was passed onto the crews. The patient liaison service was represented on the clinical governance days and we were informed the service was looking to develop a peer support service. Team support was provided by the two pastoral volunteers, with whom members of the team met with every two weeks.

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.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. The service used a range of performance indicators to measure and benchmark performance and identify where improvements were required and celebrate success. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken.

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had a risk register that reflected the up to date risk profile for the service. Risks were rated appropriately and had mitigations, time frames for review and named individuals responsible for updating and mitigating the risks. Reports demonstrated action was taken when required and improvements monitored. The risk register was comprehensive and reflected the concerns of managers and staff.

We were given two examples of how, following the identification of risk, practices had been introduced to mitigate those risks. The service does not carry packed red cells but does carry lyoplas, a type of blood plasma that is easier to store longer term and carry. The service devised and introduced systems to improve reconstituting it for injured patients.

The service has also developed a “cold” chain supply of fresh frozen plasma (FFP), in partnership with and supplied by a local NHS trust and delivered by a biker’s charity The service has worked with the local NHS Trust to develop a system that can adapt to changes in national guidance.

We saw plans for the development of the service. They had used a workflow summary for project management. Key roles were defined, and action points raised. An assessment as to the risk of likely disruption had been undertaken and how information could be shared with staff. Plans for the new unit included an impact assessment work stream for the new build project.



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The service had plans to cope with unexpected events and had up to date and detailed business continuity plans and comprehensive processes for managing major incidents. Staff knew where to find these plans and knew their role in each of them.

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 used a holistic approach to integrate their information management processes. The service had a digital audit system that tracked all their audit information which included information about cleaning schedules, incidents, safeguarding reports, and temperature logs. This system was used to monitor specific areas of risk as well as look for areas to improve the service. We found the information used to report performance and delivering quality care was consistently accurate, valid, reliable, timely and relevant with key individuals given responsibility for ensuring this was the case.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure, including those where patient records and quality and performance details were recorded.

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

The service had up to date data sharing agreements in place with key stake holder 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 and general data protection regulations (GDPR) training. At the time of our inspection staff were 100% compliant in both subjects. The service had a Caldicott Guardian, who was responsible for protecting the confidentiality of people's health and care information and to ensure it was used properly.

The service had an information governance strategy framework and had been awarded cyber essentials plus certification following a cyber essentials assessment in February 2022. The service also undertook phishing audits which examined the practice of emails being received that purported to be from reputable companies in order to induce the service to reveal personal information. We reviewed a copy of the data security and protection (DSP) tool kit submission which showed compliance with National Data Guardian standards. Staff undertook training in information governance; all 29 staff allocated had completed the module, and general protection regulations training.

Engagement

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



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Leaders and staff used innovative approaches to gather feedback from people who used services and the public. This was then used to plan and manage services. They collaborated with local, national, international partner organisations to help improve services for patients. There were consistently high levels of constructive engagement with staff, patients, relatives and external stakeholders.

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

The service had a comprehensive range of engagement processes for staff, patients, relatives and external stakeholders to participate in and make developments within the service. For example, the service took a leadership role in its health system to identify and proactively address challenges and meet the needs of the population. This is evidenced through the setting up of the HEMS dispatch team and the community outreach work. The service was also looking to expand the volunteer responder programme.

In 2021 the service was awarded “outstanding” by best companies ltd, an employee engagement specialist company who had undertaken a survey of the workforce between October and November 2019 (see above under culture). The service had also conducted bespoke surveys to gain the thoughts and views of employees on specific subjects. We were shown a survey on staff thoughts on the planned developments of the service, dated 2022. Staff were invited to give their thoughts on initiatives, such as, a paramedic in the hub, urban evening car, university links, cars in specific Devon areas, community outreach, increased time in theatre, overnight car response.

The service was planning to develop a new base and a staff survey was conducted into views on cost priorities for the new service which asked for staff comments on the proposed operational spaces. This included a training area, storage areas, operational areas (airside), aircraft and mechanical, patient and family support area. The results of which were passed to the project management team.

Another survey, conducted in 2021, referred to as “taking stock” surveyed staff attitudes and produced an action plan which included topics such as policies, organisational outcomes, duplication in mandatory training and shift changes. An email dated 5 January 2022 invited staff to register for a follow up meeting.

We spoke with staff who stated they had been supported by the service to undergo further training to develop in their role and interests. All staff spoken with confirmed they received regular supervision and there were a number of committees which they could join to be involved in the running of the service.

There were consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.

We were told the service used pastoral volunteers to provide support for staff, and that “hot” and “warm” debriefs were arranged immediately afterwards and post incident to ensure staff welfare was promoted.

Each staff member had a colleague as a nominated buddy, and dispatchers in the HEMS service could make welfare referral if they felt the nature of the incident would have impacted negatively on the crew attending. Crews could also request a change of shift. The service employs 3 qualified Trauma Risk Management (TRIM) practitioners to support staff where needed and staff had access to Red Poppy services.



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The Red Poppy company provided a counselling service to assist in resolving stress, trauma and personal problems. Staff spoken with stated there were staff meetings and the registered manager operated an open-door approach to management.

People's views and experiences were gathered through patient and relative satisfaction surveys and acted on, to shape and improve the services and culture. The service kept a database and we were shown seven positive patient satisfaction responses.

There were positive and collaborative relationships with external partners, such as a neighbouring NHS trust, to build a shared understanding of challenges within the system and the needs of the relevant population.

We were shown evidence the service's staff had provided training for outside organisations on blood issues and the service had links with two universities for the placement of students.

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 a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change.

Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There was a strong record of sharing work locally, nationally and internationally.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were consistently implemented and had a positive impact on quality and sustainability of services.

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in appropriate research projects and recognised accreditation schemes.

There were standardised improvement tools and methods, and staff had the skills to use them. Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.