Midlands Air Ambulance Charity

Midlands Air Ambulance Charity - Strensham Airbase

Inspection report

M5 Northbound Strensham Services
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Outstanding** ☆
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive to people's needs?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Managers planned staffing in collaboration with other regional providers. Staff had extensive, highly specialised training in key skills and understood how to protect patients from abuse.
- The service controlled infection risk well using specialised equipment and vehicle adaptations. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them across multidisciplinary boundaries. Staff collected safety information and used it to improve the service.
- Managers monitored the effectiveness of the service through a programme of continual auditing and benchmarking. They made sure staff were competent by providing a programme of continual professional development.
- Staff provided good care and treatment and gave patients pain relief when they needed it. The service met agreed response times and worked collaboratively with partners to meet demand. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients who were often treated in trauma situations.
- The service planned care to meet the complex, urgent needs of people, took account of patients' individual needs, and made it easy for people to give feedback. People and partner organisations could access the service when they needed it.
- Leaders ran services well using innovative, tested information systems, and supported staff to develop their skills. Staff and stakeholders understood the service's vision and values, and how to apply them in their work. They felt respected, supported, and valued.
- The service engaged meaningfully with patients and the community to plan and manage services and all staff were committed to improving services through research and exploration of new evidence-based practice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	**Outstanding** ☆	We rated this service as outstanding. Please refer to the main summary.

Summary of findings

Contents

Summary of this inspection

Background to Midlands Air Ambulance Charity - Strensham Airbase

Midlands Air Ambulance Charity – Strensham Airbase is an independent provider of urgent and emergency care services using an air ambulance (helicopter) and rapid response motor vehicles (RRVs). The service provides helicopter cover across Shropshire, Staffordshire, Herefordshire, Gloucestershire, Worcestershire, and the West Midlands and RRVs across Herefordshire, Gloucestershire, and Worcestershire. The service provides pre-hospital care and life saving interventions whilst transporting patients to hospital.

The provider registered with CQC to provide regulated activities from this location in February 2022. The service provides the following regulated activities:

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

The service has 2 registered managers and has not previously been inspected.

The Strensham Airbase operates 365 days year between 7am and 2am with air ambulance services provided between 8am and 8pm. The airbase has 1 helicopter and 2 RRVs permanently based there, and most staff work across the provider's locations. The service does not deliver care and treatment to patients on site at their registered location and instead response crews use it as a base and travel to the sites of emergency calls, such as road traffic accidents, businesses, and residential addresses.

This airbase is 1 of 3 in the provider's network and much of the quality, monitoring, and governance data are collected at provider level across all sites. Where data are available at local level, we note this in our report.

How we carried out this inspection

We carried out a short notice announced inspection of the service on 25 January 2024. Our inspection team consisted of a CQC lead inspector, a specialist advisor, and an off-site operations manager. We gave the provider notice of the inspection as we needed to make sure our inspection team could access the site.

During our inspection we spoke with the provider's senior team as well as clinical staff on duty. Our inspection methodology means we could not join clinical teams to observe practice. Instead, we reviewed clinical records, policies and standard operating procedures, and various other sources of evidence to come to our judgement.

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

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The provider went beyond the expected delivery of care to embed the service and its staff in regional communities and health economies. This ethos of collaborative working was embedded in all aspects of the service and led to improved emergency treatment options for patients through expanded reach across regional boundaries.
- Staff continuously sought opportunities for innovation and improvement. This drove exploration and research at all levels, and a working culture that was recognised and supported by the senior leadership team.
- The provider recognised its unique place in the regional health system and proactively worked with other organisations to provide training and clinical observation opportunities for their own staff. This contributed to the upskilling of wider healthcare professionals and improved understanding of the scope of service, both of which improved trauma and emergency care options for patients.
- Staff peer reviewed every instance of patient care after the service's involvement with them was complete. This provided 100% audit-based oversight of care decisions and documentation and enabled staff to continuously learn from each other.
- The provider had developed an extensive safeguarding system that reflected the high-risk nature of care provided. The senior team had established working links with local authority safeguarding teams in order to contribute to learning from child deaths, patients experiencing abuse, and those treated for self-harm or injuries from attempted suicide. This reflected a detailed system developed to address the different working practices across the provider's areas of operation.
- Governance systems were advanced in scope and design and provided senior staff with in-depth, continuous oversight of quality, safety, and performance. The team had developed and nurtured the system over time, adapting to learning situations. An ethos of independent, ethical practice in decision-making underpinned the system, which minimised the risk of bias.
- The service had completed a substantive programme to review the effectiveness and appropriateness of post-treatment patient liaison. Modelled on a critical care approach, trained, and dedicated staff assessed the needs and treatment of each individual to identify if they would benefit from engagement with the team. This helped patients who experienced traumatic incidents to reduce anxiety and promote recovery by filling in memory gaps.

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Emergency and urgent care

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

Is the service safe?

Outstanding ☆

We have not previously inspected or rated safe. We rated it as outstanding.

Mandatory training

The service provided mandatory training in key to all staff and made sure everyone completed it. Staff were encouraged to participate in learning to improve safety as much as possible, including participating in local, national, and international safety programmes.

Staff received mandatory training based on their role. Training and education were a substantive focus of the provider and staff had protected, rostered time for learning completion.

All staff completed 20 mandatory training modules supplemented with a range of clinical skills and non-clinical skills programmes. At the time of our inspection the provider reported 84% compliance with training requirements across operational staff. This reflected the nature of the staffing model, which included individuals who did not work substantively for the service. The registered managers monitored compliance and supported staff to access training.

Staff used a clinical skills training room and an immersive environment to complete practical simulations at the provider's headquarters. There was a consistent focus on practice, in-person training in recognition of the high-quality practice this supported.

The provider monitored opportunities to access training in new clinical programmes and standards of practice. For example, the senior team implemented new training on the Deprivation of Liberty Safeguards and new practical training in resuscitation to better meet patients' needs and reflected the latest understanding in each area.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. From April 2024, non-clinical staff would complete autism awareness, first aid, and basic life support training.

Emergency and urgent care

The provider completed an education and training needs analysis to track mandatory training and identify needs in clinical governance, clinical, and non-clinical skills. The system enabled the senior team to obtain snapshots of training completion and need at any given time. For example, if clinical governance meetings identified a need for new or enhance training, the needs analysis system enabled the senior leadership team to incorporate it into training plans.

Safeguarding

The provider had comprehensive systems to keep people safe, which took account of current best practice. The whole team was engaged in reviewing and improving safety and safeguarding systems. People who used services were at the centre of safeguarding and protection from discrimination. The provider encouraged innovation to achieve sustained improvements in safety and continual reductions in harm.

Staff received training specific for their role on how to recognise and report abuse. Levels of safeguarding training reflected the nature of enhanced care. For example, 4 members of staff were trained to safeguarding adults and children level 4 and all clinical staff were trained to adults and children level 3. Aircraft pilots and non-clinical staff completed safeguarding training level 1, which reflected national guidance as all staff had the potential to come into contact with patients and their relatives.

The clinical operations director was the safeguarding lead and along with the registered managers and volunteer manager, they maintained safeguarding as a standard agenda item at clinical operations and standards meetings.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They delivered care and treatment in environments and scenarios that were often challenging and highly emotive and worked to make sure care was equitable and took account of individual vulnerabilities.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff recorded safeguarding concerns and referrals on an electronic system also used for incidents. The service kept safeguarding referrals open on the system until they received a resolution or outcome.

The service was proactively and extensively working with local authorities to improve engagement across the region and promote better outcomes for patients. For example, they established working relationships with child safeguarding and protection boards and contributed to serious case reviews including child death investigations.

Safeguarding reports reflected a proactive approach from staff in recognising and acting on safeguarding risks, including liaising with local authorities to establish if patients were known to them. This included in situations where children were at risk from parents under the influence of alcohol and drugs, domestic violence, neglect, and self-harm.

The safeguarding trustee lead, responsible director for safeguarding, chief operating officer, and the head of quality and compliance (CQC registered manager), convened the safeguarding working group every 3 months. Meeting minutes demonstrated good standards of consistency and involvement with clinical teams, including following up with other providers involved in care.

In the previous 12 months staff reported 7 safeguarding incidents. None of the incidents resulted from care delivered by staff and instead were concerns raised by staff to local authorities relating to neglect, self-harm, and abuse.

Cleanliness, infection control and hygiene

Outstanding ☆

Emergency and urgent care

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

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

The service performed consistently well for cleanliness. Staff used a series of processes, checks, and audits to ensure vehicles and equipment were clean and to provide assurance of consistent infection prevention and control (IPC) standards. The provider contracted a specialist external organisation to carry out deep cleans of cars. Staff completed training to deep clean the helicopter themselves, ensuring such work reduced risks to patients and maintained the safety of essential flight equipment.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All vehicles were deep cleaned every 3 months on a planned schedule. Staff arranged on-demand deep cleans following spillages or contamination. The deep clean process included pre- and post-cleaning bacterial swabs of surfaces as a tool to measure effectiveness.

Staff followed infection control principles including the use of personal protective equipment (PPE). Aircraft and vehicles were equipped with stocks of PPE including to protect staff when managing bleeds and trauma injuries. All clinical staff had training in its use and aircraft pilots completed training

The provider adapted to providing clinical care in the aircraft by modifying usual IPC processes. For example, staff used absorbent blankets to reduce the need for deep cleans. The floor of the aircraft was fitted with a medical grade covering with a fluid drainage system. Such features protected electronic systems from damage and reduced down time for cleaning, which could impact the response to an incident.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles, and equipment kept people safe. The service sought bespoke, highly specialised advances to standard operating processes. Staff were trained to use them. Staff managed clinical waste well.

The design of clinical environments followed national guidance. The provider had adapted aircraft and rapid response vehicles using international standards and maintained these in line with manufacturer instructions. Each member of staff on duty participated in allocated daily base checks. This included checks of clinical equipment, such as charged batteries and stock levels. The process meant staff maintained a continuous state of readiness to provide emergency care.

The service used a police maintenance specification to maintain cars to a level higher than that required legally for this type of service.

The service equipped vehicles and aircraft with fully kitted clinical equipment and emergency bags that meant staff could achieve fast turnarounds during shift changes and moves to different locations. The team used a colour-coding system for equipment to help staff more quickly identify items and support accurate and fast restocking.

Staff used a stock rotation system for consumables and equipment and maintained thorough document control records.

Emergency and urgent care

Staff carried out daily safety checks of specialist equipment and the senior team used the electronic system to continuously monitor levels of compliance. Staff carried out monthly quality checks and arranged ad-hoc maintenance and repairs through third party contracts. The provider had a planned preventative maintenance and servicing system for vehicles and equipment. Staff ensured the service was continuously operational by planning in advance to move resources around the location network.

Staff disposed of clinical waste safely and in line with national guidance. They used local streaming processes for the safe handling of waste brought back to the airbase and staff used service level agreements with other providers where they could dispose of waste at other sites, such as hospitals.

An external contractor owned, operated, and provided maintenance for the helicopter. The provider had a maintenance agreement that meant most work took place out of hours and the supplier would provide a replacement aircraft within 24 hours if a fault could not be fixed immediately. The aircraft had 98% reliability in the previous 12 months.

While the service did not provide care for patients at the provider's registered address, the senior team maintained safety standards to keep staff safe. This included regular fire safety training and Legionella checks on the water supply. The local base team had prepared a photographic guide to the use of emergency equipment, such as first aid kits and eye wash stations. This supported staff who worked for the provider occasionally and those who were unaccustomed to this site. It also provided assurance for staff who frequently changed work location that they could readily access equipment.

Staff carried out a monthly quality assurance audit of each rapid response vehicle. The audit included a check of key equipment, such as syringe drivers, and random checks of the expiry dates of consumables. Auditors also checked for damage that would impact the effectiveness of cleaning and disinfection. In the previous 12 months audits found over 99% compliance with expected standards and staff documented action where they found areas for improvement.

The provider maintained continuous airworthiness management certification for aircraft through an external support contract.

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. Staff had a proactive, embedded approach to anticipating and managing risks to people who used services.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Clinical staff were trained to provide trauma care, including airway management, and used electronic monitoring tools to provide detailed handover information to receiving hospitals or other ambulance services.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The senior team monitored completed of risk documentation through quality assurance checks on electronic records.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. The provider had introduced new mental health training for staff and clinical teams were in the process of completing this. The training would help support communication and assessment of patient needs.

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. They worked with other organisations, such as local authorities and the police, to coordinate care.

Staff shared key information to keep patients safe when handing over their care to others. They used handovers to discuss all necessary information to keep patients safe. Some providers did not have electronic patient record systems that were compatible with this provider's systems. Staff knew which providers this related to, and they completed separate handover documentation to provide on arrival with a patient.

During air transfers, clinical staff worked with the pilot to ensure the weight and balance of the aircraft were safely managed. They arranged equipment in the aircraft to facilitate this, such as by using a dedicated area for airway management, which involved the use of more equipment. The onboard stretcher had a maximum weight of 150kg, and staff established safe working processes for treating bariatric patients.

The provider managed risks relating to aircraft in conjunction with guidance from the Civil Aviation Authority, such as for pilot fatigue, in-flight emergencies, and injuries. The provider required all staff who could drive rapid response vehicles to complete Section 19 driver assessments, which established the provider's non-profit status in line with the government's public service vehicle operator requirements.

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 and agency staff a full induction.

Most staff worked across the provider's locations within a flexible, responsive scheduling system. A team of 159 staff worked in the 2 divisions responsible for regulated activities, including 30 doctors and 29 critical care paramedics (CCPs). A part time pharmacist, who was in a substantive position elsewhere, provided medicines management support.

Clinical staff held significant experience in the sector providing emergency pre-hospital care. Doctors were a mix of consultant intensivists, anaesthetists, and emergency medicine specialists and most CCPs had experience of working in enhanced care in NHS ambulance services. The provider accepted doctors at a minimum grade of specialist registrar (SpR) with critical care and emergency care experience and supported their progression. The service also had provision for military doctors working under contracts managed jointly with the military department. Each doctor committed to a minimum of 1 day per month in the service to ensure they remained up to date with processes.

Turnover was low and no staff had left the service in the previous 12 months. Sickness was consistently low and less than 2% in the previous 12 months. This reflected structured support provided to all staff and a positive working culture. To meet increasing demand, the service recruited 3 pre-hospital emergency doctor trainees and 2 trainee CCPs. An in-house, dedicated human resources team managed recruitment processes that met national legislation.

Aircraft operated with a single pilot who was employed by the aircraft operator. Each flight included 2 crew members, a doctor and a CCP, trained to support the pilot with navigation and communications.

The provider's medical director and human resources team maintained oversight of each doctor's General Medical Council (GMC) registration and annual appraisal.

Emergency and urgent care

The provider's established staffing cover was 1 doctor and 1 CCP for air ambulance cover during the day and 2 CCPs for rapid response vehicle cover overnight. The provider secured doctor cover overnight based on individual availability.

Records

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

Staff used a bespoke electronic patient record system designed by clinicians working in enhanced care provision. The system captured monitoring data, such as vital signs, and provided staff with a seamless patient handover tool to other providers.

Patient records were comprehensive, and all staff could access them easily. Duty doctors and CCPs could access records remotely and used the system to provide on-demand reviews and second opinions.

In some cases, the records system had connectivity with those of other providers, which enabled staff to transmit clinical data to hospital teams awaiting a patient's arrival. The provider was working with other organisations across the region to establish greater coverage, which would improve patient care.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff not only met good practice standards in relation to national guidance, they also contributed to the evidence-based development of national guidance.

Staff followed systems and processes to prescribe and administer medicines safely. They completed medicines records accurately and kept them up to date. CCPs completed medicine competencies that enabled them to administer specific life-saving medicines. A doctor was always available on-call and could provide remote support, including by video link, to CCPs.

Staff stored and managed all medicines and prescribing documents safely. The service used secure, restricted-access storage for prescription-only medicines and Controlled Drugs (CDs). Storage included a remote temperature monitoring system that alerted staff by e-mail if the temperature exceeded safe limits.

Staff carried out regular audits of medicines to maintain assurance of safe standards of practice. The provider was in the process of introducing an electronic CD register and operated a dual system during the transition period.

Staff learned from safety alerts and incidents to improve practice. The senior team and pharmacist monitored national patient safety alerts and took action through the operations and governance systems to ensure polices and standard operating procedures were updated. In the previous 12 months staff reported 3 incidents relating to medicines, 2 of which were near misses. None of the incidents resulted in patient harm and in each case the team worked together to identify how practice could be improved and risk reduced.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Doctors and CCPs had training in chemical restraint and use this under specific pre-defined circumstances, such as if the safety of an aircraft was put at risk due to violence or action resulting from a mental health crisis.

Outstanding ☆

Emergency and urgent care

Incidents

There was a genuinely open culture in which all safety concerns raised by staff and people who used the service were highly valued as being integral to learning and improvement. All staff were open and transparent, and fully committed to reporting incidents and near misses. The level and quality of incident reporting included the levels of harm and near misses, which ensured a robust picture of quality.

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 participating in local, national, and international safety programmes. The provider identified opportunities to learn from external safety events.

Staff knew what incidents to report and how to report them. They used the reporting function of the provider's electronic operations and governance system to submit incident reports, near misses, and to document less serious concerns.

Managers shared learning with their staff about incidents that happened elsewhere. The service worked collaboratively with a range of other providers, including NHS ambulance services, hospitals, and local authorities. The provider had established information sharing and learning agreements with other organisations, which enabled both services to review incidents and jointly consider learning. For example, a recent incident related to the delayed dispatch of a rapid response vehicle due to the absence of an agreement with the booking service's operations centre to enable direct allocation of tasks. Another incident related to delayed care when a cardiac team did not escalate the needs of an inbound patient. In each case the senior team worked with their counterparts in the other organisation to identify opportunities such as improved policies and safer ways of working together.

Where incidents related to aircraft and in-flight safety, staff worked with the helicopter operator, pilot, and others involved in the situation to explore safety implications. For example, an incident occurred where a hospital did not fulfil the agreed 20-minute advanced warning request by the provider, which meant helipad landing lights were switched off and the fire service was not ready when the aircraft approached. This meant the pilot delayed landing and therefore urgent treatment. The provider sought an urgent review with the hospital about the inbound aircraft procedure as a result.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Patient liaison officers took a lead role in this.

The incident reporting system automatically alerted relevant members of the senior team when staff documented specific events. For example, the system e-mailed the medical director when the nature of an incident meant a senior review was needed.

Staff received feedback from investigation of incidents, both internal and external to the service. They met to discuss the feedback and look at improvements to patient care. The provider facilitated an overarching culture of learning from incidents that led to substantive changes and improvements. Staff were demonstrably committed to this process and developed innovative approaches to reduce previously unknown risks that were highlighted following incidents. For example, staff had previously carried ampules of CDs in secure bags that kept items safe but occasionally resulted in ampule breakages. A member of the team custom designed foam inserts to protect glass ampules, fitting them specifically to medicine bags. They added industry standard colour coded stickers to each foam insert so staff could immediately identify the medicine they needed.

Outstanding ☆

Emergency and urgent care

The incident reporting system enabled staff to document near misses and the whole team worked together to identify opportunities for improved practice. For example, as a result of a near miss, the provider required rapid response vehicles to always have live medical kits in situ whenever they were in use, even when the vehicle was not being used for service. This followed an incident in which a CCP driving a vehicle witnessed a road traffic accident whilst off duty but could not provide full assistance because the vehicle was not equipped to deliver care.

In the previous 12 months staff reported 27 incidents, of which 10 related directly to the provider. The senior team identified 5 themes including safeguarding, dispatch systems with other providers, medicines, equipment, and patient care. Incidents were evidence of positive reporting culture in which staff worked openly to reduce risk and human error. For example, 1 report detailed a near miss in which an incorrect medicine had been drawn up ready for use in a medical kit. The member of staff found the issue through a routine quality check and used the auditing process to explore how the incident happened. Another report detailed an electrocardiogram (ECG) that was providing clearly inaccurate readings. Staff recognised this and acted to keep the patient safe. They tried to replicate the conditions in which the ECG malfunctioned as part of the investigation.

Is the service effective?

Outstanding ☆

We have not previously inspected or rated effective. We rated it as outstanding.

Evidence-based care and treatment

The service provided truly holistic care and treatment based on national guidance, evidence-based practice, and research. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to the latest practice and international guidance. The senior team benchmarked policies and practices against other air ambulance and pre-hospital emergency care services.

When handing over patients to hospital colleagues, staff routinely referred to their psychological and emotional needs. The team recognised the impact of delivering care in traumatic circumstances on patients' wellbeing and mental health and provided individualised support.

The provider had implemented a new electronic system to provide remote access to policy updates, incident reports, and priority notices for all staff. The system provided an audit trail of when staff accessed and read each message as an assurance tool. This meant part time staff and those returning from time away had to catch up with changes and messages before they resumed work.

A guideline review group monitored polices and standard operating procedures (SOPs) and proposed updates where guidance changed or learning from feedback identified opportunities for improvement. This group supplemented governance processes and gave the provider assurance that staff understood and followed the latest guidance available across the sector.

Emergency and urgent care

The service worked with professionals in other organisations to establish evidence-based policies and SOPs. For example, the team worked with NHS doctors to establish a protocol for administering anti-convulsion medicines in certain circumstances. Such work reflected the deep learning culture in the organisation and the drive for continuous improvement amongst staff.

Staff adhered to a wide range of national evidence-based guidelines to deliver care at the leading edge of current knowledge. For example, they followed recent research findings regarding the transport of patients who experienced a hyper acute stroke to promote a good clinical outcome.

The provider audited staff on the use of the regional trauma tool and the decision-making process they used to select the destination hospital. In all cases in the previous 12 months, staff met the provider's expected standards.

The senior team monitored guidance and evidence-based practice from royal colleges such as the Royal College of Emergency Medicine. This particularly helped staff deliver effective trauma care.

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 were proactive in exploring and testing innovative approaches to pain relief.

Staff assessed patients' pain using age-appropriate recognised tools and gave pain relief in line with individual needs and evidence-based practice. Staff used visual aids to help assess the level of pain in patients who could not communicate verbally.

Patients received pain relief soon after it was identified they needed it. Staff used clinical observations, recorded every 5 minutes, to continuously assess pain.

Staff prescribed, administered, and recorded pain relief accurately. Patient group directions and paramedic exemptions meant non-prescribers could effectively administer pain relief from the formulary.

Response times

The service monitored and met agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements.

The provider did not operate under commissioning arrangements and instead worked on demand by other services in the region. Staff had a demonstrable focus on safe, effective dispatch that prioritised aviation safety when establishing how quickly crews could reach a patient.

The service carried out a review of mobilisation times in 2023 to identify barriers to rapid dispatch in areas such as policies or staff behaviour. The results highlighted areas for more awareness in human factors, such as tasks staff undertook between a dispatch call and leaving the base. The provider incorporated this into briefings and training.

The provider audited launch times for rapid response vehicles and the air ambulance against benchmarked standards. In the previous 12 months, staff achieved an air ambulance launch within 5 minutes in 83% of cases. This was significantly better than the benchmark of 75%. In the same period, staff met the 92% benchmark for car launches within 2 minutes of a call.

Patient outcomes

All staff actively monitored the effectiveness of care and treatment through continual, extensive assessment processes. They used the findings to make improvements and achieved good outcomes for patients that consistently exceeded expectations.

Outcomes for patients were positive, consistent, and met expectations. Clinical staff peer reviewed every case, usually within 24 hours of care and treatment. The process focused on best interest decision-making and enabled staff to review the actions of colleagues in the context of provider policies and national guidance. This was a substantive process at the centre of the provider's governance and quality assurance systems because it provided continuous assurance of standards of practice. Staff recommended cases for further review or action in a variety of settings such as governance training days and through senior colleague review. The process supported learning from patient deaths and acted as a safety net for external reporting, such as to safeguarding teams.

The provider used a programme of 28 audits and reviews to monitor clinical care and outcomes. The team used 12 key performance metrics (KPMs) as themes within the audits to help structure an understanding of outcomes over time. KPMs included the time from dispatch to on-scene arrival, management of cardiac arrest, and the use of sedation. Each KPM had an associated range of expected standards of practice and care, which the clinical performance system enabled staff to document and monitor.

Clinical outcomes were consistently positive. In the previous 12 months staff maintained 100% compliance with expected standards when administering blood products. In the traumatic brain injury audit, staff maintained 94% compliance, which was better than the provider's benchmarked data. Where audits found a need for improvement, the senior team implemented support and learning mechanisms and tracked this information in a learning log. For example, an audit of open fractures identified a need for more consistent administration of antibiotics to patients. The cardiac arrest audit highlighted a need for more consistent documentation of electrocardiogram results.

Audits of patient outcomes and staff practices demonstrably contributed to improved evidence-based practice and research-led SOP development. For example, an audit of paediatric intubations by critical care paramedics (CCPs), a typically very difficult procedure, led staff to review the use of pre-hospital emergency anaesthesia against Association of Anaesthetists guidelines. In areas of clinical practice such as this, where there were widely differing viewpoints on treatment approaches and efficacy, staff worked together to review the most recent research findings and international practice standards. They applied these to the specific needs of the service and data on previous patient care to establish the most appropriate SOPs and policies. The audit of paediatric intubations was an example of internal audits suggested by staff based on their experiences, which reflected the collaborative, educational nature of the service.

Audits often incorporated several different aspects of care. For example, an audit of open fracture management found consistent standards of antibiotic administration, with 99% of patients receiving the guideline medicine or having a clearly documented reason for omission.

In addition to the range of clinical outcomes monitored through audits and KPMs, the provider measured outcomes through feedback from patients and their loved ones. For example, many patients contacted to the service to discuss their recovery and commented on how the care they received impacted their lives.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Some members of the senior leadership team were qualified critical care paramedics (CCPs) or worked in other clinical areas. For example, the patient liaison lead and head of clinical operations were both CCPs and the clinical logistics manager was the Controlled Drugs lead. Such interdisciplinary roles ensured there was substantial representation of clinical expertise at all levels of the service.

The head of education and training held clinical teaching qualifications as well as significant experience in pre-hospital care. They were utilising their experience in higher education to drive a programme of improved training and learning opportunities for staff.

CCPs completed a rotating programme of clinical placements in hospital surgical theatres and critical care units. The provider allocated 28 hours per year for each CCP to carry out hospital placements.

The provider maintained oversight of a comprehensive training programme for staff who provided care and treatment on the air ambulance. Staff undertook specialist in-flight training with the aircraft owner and operator. This included crew resource management (CRM), flight safety, navigation, and communications training. Each member of staff completed an annual line check for aircraft safety and 3-yearly fire safety and evacuation training. CRM training included error management, threat management, and cognitive failures. Such specialist areas meant staff were equipped to work to a high standard in a challenging environment.

Managers gave all new staff a full induction tailored to their role before they started work. Many staff had worked for the organisation under a previous identity before it gained independence and charity status. This team worked together to transition policies and practices and to support new colleagues.

The on call clinical team carried out a daily case-based discussion, called 'topic of the day'. This was designed to review a recent case in the context of the provider's policies and, check the knowledge of the team, and identify opportunities for improvement.

Each CCP underwent an annual appraisal, participated in peer review shifts, and assessed interventions as part of post-treatment quality reviews. This provided a well-rounded, comprehensive view of performance and competence.

The provider placed significant value on training and development. They allocated CCPs 50 hours per year to complete training, which included clinical programmes such as advanced competency simulations for the administration of medicines. All staff had access to a skills training room and an immersive environment equipped for simulation and practical scenario training.

The provider was developing in-house training provision, including in surgical skills, ultrasound, and maternity and neonatal care. Such work reflected the provider's drive to meet changes in demand.

Outstanding ☆

Emergency and urgent care

The provider was a host organisation for the Intercollegiate Board for Training in Pre-Hospital Emergency Medicine. Doctors selected through a competitive national programme, at a minimum grade of ST4, completed clinical training with crews. The provider also supported doctors and paramedics to complete fellowship programmes with individual training objectives. This reflected the provider's investment in training and establishing sustainable skills in the sector.

Clinical staff who provided care from the air ambulance completed helicopter emergency medical services (HEMS) training to become a technical crew member (HTCM). This meant the provider could secure certain operational exemptions from the Civil Aviation Authority and operate the helicopter in more situations. The pilot checked HTCM competency each day before the start of the service as part of the provider's aviation safety responsibilities.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. They worked across health care disciplines and with other agencies when required to care for patients. Response to incidents was often multiorganisational and staff worked with colleagues in emergency services, hospitals, and other healthcare providers to coordinate care and treatment. There was a demonstrable enthusiasm at all levels for working with other agencies to improve patient care and the senior team proactively liaised across the region to establish sound working relationships and agreements.

Enhanced care teams provided a wide range of pre-hospital care, including the management of critical illness, trauma management, advanced ventilation, anaesthesia, and magnesium sulphate infusion. Magnesium sulphate infusions is used to treat conditions such as severe anaphylaxis and life-threatening asthma.

Pilots worked for the organisation that provided helicopter maintenance and regulatory oversight. They worked closely with the provider and enhanced care teams to make sure patient transfers and inflight treatment was safe and in the best interest of everyone given then working environment and complex patient needs.

Staff worked with multidisciplinary colleagues to implement new treatment options and clinical equipment. For example, the service noted an increase in calls for treatment to pre-term babies. As a result, they worked with specialists to equip cars with neonatal care equipment, ensuring the items included were those most likely to be of use.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. For example, the nature of the service meant staff often provided life-saving treatment to patients who were unconscious or otherwise unable to consent. They were trained to make clinical decisions using all the evidence available to them.

Outstanding ☆

Emergency and urgent care

Staff received and kept up to date with training in the Mental Capacity Act 2005. The provider had introduced training in the Deprivation of Liberty Safeguards and all staff would be trained by the end of 2024.

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. The service had established close working relationships with children's and social services teams in local authorities and worked collaboratively to support care delivery with vulnerable young people.

The provider tracked consent documentation as part of an ongoing audit of standards of practice. In the previous 12 months staff met consent requirements in 93% of cases. As part of a drive to increase compliance and improve consistency, the provider was working with the software supplier to make consent documentation mandatory while processing patient information.

Is the service caring?

Outstanding ☆

We have not previously inspected or rated caring. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and went above and beyond expected care to take account of individual needs.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. The provider had developed a feedback system that reflected the nature of the service. For example, many patients were treated for trauma conditions and required extended periods of recovery, including for memory loss. Staff provided care and communication focused on empathy and understanding, recognising that was often delivered in distressing circumstances.

Patients and their loved ones said staff treated them well and with kindness. Feedback was consistently positive and almost all written messages referred to the kindness and compassion of staff.

In the previous 12 months, 100% of patients who provided feedback said they felt safe with the clinical team and said they were treated with kindness, compassion, and dignity.

The provider recognised the nature of care provided often meant they could not easily obtain feedback from patients. Instead, the team sought other ways to gain assurance of how their care was perceived. For example, the service asked clinical observers to rate the kindness, compassion, dignity, and respect shown by crews during treatment. Observers rated staff highly and in the previous 12 months, 95% gave the maximum score possible in these measures.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal needs and provided individualised care that reduced worry and anxiety.

Emergency and urgent care

Staff gave patients and those close to them help, emotional support and advice when they needed it. They supported patients who were distressed and helped them maintain their privacy and dignity. Staff often delivered care in life-threatening circumstances and were trained in breaking bad news and how to demonstrate empathy when having difficult conversations. For example, staff recognised the emotional impact of injured children and the elevated needs of vulnerable people. They worked together to provide empathetic care considering the specific circumstances.

Post-treatment patient liaison and engagement was a key element of the provider's work to ensure patients received the continuing emotional support they needed to make a good recovery. For example, many patients who experienced a trauma could not remember their treatment or transfer to hospital. Saff worked with them to fill memory gaps and reduce anxiety during recovery.

The provider embedded compassion and emotional support in all areas of the service and reflected this with high levels of expectations and requirements of staff. For example, managers used scenario-based exams during staff recruitment to test natural empathy and how well individuals could communicate bad news.

The nature of pre-hospital enhanced care meant some patients died despite the best efforts of staff. Staff had developed extensive support systems for relatives, friends, and carers and proactively worked to provide care and support. Feedback from relatives provided a substantial, long-term record of the compassion and psychological support staff provided. For example, the relative of a patient who did not survive an accident contacted the service to praise the compassion and professionalism of staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment. The service sought to maintain a continual understanding of patient need, expectations, and understanding.

Staff made sure patients and those close to them understood their care and treatment. They talked to patients in a way they could understand, using communication aids where necessary. This was often challenging due to the circumstances in which care was delivered and staff were trained to manage fractious situations and use communication effectively to establish trust with the patient and others around them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service provided a range of feedback channels as part of a comprehensive aftercare programme. Feedback was consistently positive. In the previous 12 months, the airbase received 8 formal compliments. Compassionate care that involved the patient and those close to them was a key theme, particularly in highly challenging scenarios. For example, the relatives of an injured child complimented the service on how well staff provided care and reassurance to those around the patient, including grandparents and a family member with complex needs.

The nature of enhanced pre-hospital care meant some patients would die during treatment. Patient liaison leads, who were qualified critical care paramedics, worked with the loved ones of patients who died to help them understand the nature of their injury or disease and signpost them to appropriate support.

Staff worked extensively to provide care and support beyond immediate care needs. For example, a crew worked with a family to secure emergency, temporary housing after finding they were in highly vulnerable circumstances during a call out. This reflected the holistic, dedicated approach of staff to provide care beyond patients' immediate needs.

Outstanding ☆

Emergency and urgent care

In the previous 12 months, 100% of patients who provided feedback on the care they received said staff provided open and honest information on their condition and care.

Is the service responsive?

Outstanding ☆

We have not previously inspected or rated responsive. We rated it as outstanding.

Service delivery to meet the needs of people

The service planned and tailored care in a way that met the needs of people and the communities served. It worked extensively with others in the wider system and local organisations to plan care that was flexible and offered continuity of care.

Managers planned and organised services, so they met the needs of people across the region. The provider recognised the service was part of a wider system and network of care and the senior team proactively engaged with other organisations to establish systems of streamlined care. For example, the team had sought working relationships to benefit the service's responsiveness with NHS hospitals and ambulance trusts, integrated care boards (ICBs), other private providers, and safeguarding teams.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems. They liaised with receiving hospitals to arrange such care and worked with local authority safeguarding teams to establish appropriate social service support.

Staff used standard operating procedures for behaviour management and were trained in the use of chemical restraint. This would be a joint decision with the pilot and adhered to aviation safety requirements. This reflected a comprehensive programme of work to balance the needs of patients with acute medical conditions and the safety of the aircraft and crew.

A senior consultant was on call 24/7. They provided remote advice to critical care paramedics (CCPs) in challenging circumstances, such as amputations or intubation decision-making. The on-call consultant also provided remote review of patient care and treatment using the electronic records system and supported staff with debriefs after incidents or significant events.

Meeting people's individual needs

The service was inclusive, and staff proactively 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 and worked to reduce stigma and improve accessibility.

The nature of the service meant care and treatment were not usually pre-planned or elective and instead staff provided time-critical treatment in challenging situations. This meant it was not often possible for staff to understand patients' non-clinical needs relating to personal preferences, culture, and religion. Instead, the team worked to provide the

highest standard person-centred care possible. The sought input from the loved ones of patients at the scene of treatment, worked together with local service providers that knew the patient, and followed learning from previous instances of treatment. The patient liaison leads worked closely with clinical crews to help develop communication skills that were effective in high risk or traumatic scenarios.

The provider's structured, patient-centred approach to engagement substantively contributed to outcomes and quality care. For example, the work produced evidence of learning and service improvement as a result of feedback and incorporated relationships with patients, relatives, and carers into clinical quality work. Patient liaison leads, who were critical care paramedics, monitored and tracked the number of aftercare contacts, referrals, and ongoing support relationships to streamline the process to patients who stood to gain the most benefit.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were skilled in assessing patients' most immediate needs in life-threatening scenarios and provided details of additional needs during handovers.

Staff carried blood supplies as part of an agreement with a local NHS hospital. They rotated blood stock every 48 hours with the hospital's critical care service. This ensured crews were prepared to support major bleeds and trauma cases without delay.

Staff completed training in providing care to people living with a learning disability, autism, and dementia. The service did not routinely provide care and treatment to patients with conditions such as these and the training provided familiarisation to help staff communicate effectively and understand how to meet individual needs.

Access and flow

People could access the service when they needed it and received the right care promptly. The service focused on increasing capacity and access to meet demand.

The service operated on demand from other emergency care providers and did not have commissioned targets for response times. Instead, the provider audited and benchmarked access times internally. For example, the team audited launch times for rapid response vehicles and the air ambulance against benchmarked standards. In the previous 12 months, staff achieved an air ambulance launch within 5 minutes in 83% of cases. This was significantly better than the benchmark of 75%. In the same period, staff met the 92% benchmark for car launches within 2 minutes of a call.

Staff supported patients when they were transferred between services. All patients were transferred to another provider at some stage in care and treatment and staff worked collaboratively with colleagues to support a smooth transition. They achieved this by sharing clinical information in advance and providing holistic information during handovers.

Aircraft operations typically took place between 8am and 8pm dependent on weather conditions. The service had trialled a 24-hour enhanced care service in 1 region with the provision of a rapid response vehicle (RRV). An RRV was available at all times to back up the flight crew in the event weather or operational problems grounded the helicopter. This provided assurance of reliability and meant patients could access care when they most needed it.

The service was working with NHS ambulance services to achieve direct dispatch capabilities. This would mean 999 operations centres could dispatch an air ambulance or SSV without the need to pass the request through another provider.

Outstanding ☆

Emergency and urgent care

The provider had established an operational agreement with another air ambulance service in the region. This enabled operations staff to track aircraft in the region and identify areas with the most need in the event of an incident or emergency.

In the previous 12 months the service reported 12% of patients were carried by aircraft.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns seriously and had systems to investigate complaints and share lessons learned with all staff, including those in partner organisations. Patient liaison leads had developed processes to include people in the resolution of their complaints.

People could access the complaints policy through the provider's website or by contacting the service directly. The policy was up to date and although rarely needed, the senior team ensured feedback could be handled in the complaints pathway if needed.

While the service received no complaints in the previous 12 months and 2 since it became independent. The patient liaison team had established new protocols and ways of working as learning from past complaints and feedback. For example, the team had established agreements with NHS ambulance trusts to co-manage complaints that included elements of both services. This would provide patients with an understanding of how situations happened when managed by more than 1 organisation.

The complaints management process involved face-to-face discussion with the complainant as part of a strategy to resolve problems and concerns more actively. This resulted from learning from a historic complaint, in which staff identified potential barriers to resolution by relying on phone calls and e-mails. It reflected a profound, embedded focus on understanding how patients and their loved ones felt about care and treatment.

Is the service well-led?

Outstanding ☆

We have not previously inspected or rated well-led. 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 through a proactive, forward-thinking approach. They were visible and approachable in the service for patients and staff and had a clear track record of effective leadership strategy. They supported staff to develop their skills and take on more senior roles through ambitious goals.

The board of trustees maintained oversight of the provider's operation and the chief executive officer and registered managers had overall leadership responsibility. The chief operating officer and 3 directors each led divisional teams.

Senior staff worked across all 3 of the provider's airbases, including 2 registered managers. They formed the senior leadership team (SLT) alongside the head of clinical operations, medical director, clinical logistics manager, clinical operations director, and the base lead. The base lead was a permanent presence at this base and supported local operations and practice. This was good practice because it meant the base operated within the provider's consistent standards of quality and performance but with distinctive local leadership for staff, development, and innovation.

A senior consultant and a duty manager were on call 24/7 and equipped to make leadership decisions.

The provider had a clear chain of command in the event of an emergency that interrupted usual service operation and paramedics were trained to provide interim leadership and decision-making in an emergency.

Staff and patients spoke highly of the senior team and said they were always available for help and support, including pastoral support after challenging shifts.

The leadership team had a demonstrable sense of pride and accountability and had a track record of building the service with care and treatment to meet the needs of specialised contractors. Patient and staff safety was a core priority and was embedded in all elements of the service.

The service encouraged and supported ambulance technicians to progress through the paramedic training scheme as part of a leadership strategy focused on securing long-term, highly qualified, and experienced professional staff to deliver urgent and emergency care (UEC).

Vision and Strategy

The service had a vision for what it wanted to achieve and an ambitious strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to plans across regional specialist health economies. Leaders and staff understood and knew how to apply them and monitor progress.

The provider's vision focused on delivering life-saving treatment before patients arrived at hospital. Underpinned by an overarching mission focused on patient care and 5 key values, the vision reflected the diverse nature of demand on the service and the model of care by focusing on the challenges associated with helicopter-led emergency medical services.

Staff embodied the organisation's values of safety, a caring focus on patients, and an open and honest culture that was team oriented. This was reflected in the demonstrable passion staff had in their work and the provider's low rates of staff turnover.

The provider had a well-developed rolling 5-year strategy centred on clinical excellence. The strategy model involved an annual review and evaluation followed by the addition of another year to maintain momentum.

The service established high standards for staffing and the exclusive use of qualified professionals reflected a strategy of providing care only with experienced staff with advanced levels of training.

Staff were actively involved in the provider's values and wider vision. They understood how both applied to their work and how they could use them to improve care and innovate services. All staff were empowered to make suggestions and proposals for how the service could deliver on its strategy.

Outstanding ☆

Emergency and urgent care

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients and continuously sought opportunities for joint working and improvement. 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 and in which the senior team wanted to understand challenges.

The SLT promoted an ethos of professionalism, empowerment, and accountability amongst the team. Staff represented the provider at high-profile events and demonstrated a clear sense of pride, confidence, and enthusiasm in their work. The service often attracted interest from the media and press and staff were trained to ensure the discretion and privacy of patients, which were core values of the organisation.

Staff reported good relationships with the SLT. They said communication was a positive aspect of working there. For example, staff said they had no hesitation in speaking with either senior leader if they needed to raise a concern.

Mentors worked with new staff to support their introduction to the organisational culture including care and treatment ethics. They empowered an ethos of individuality in the workplace and the senior team demonstrably valued diversity and equality.

There was an embedded focus on collaborative working with NHS ambulance trusts other emergency services such as the police. Joint working and an empowered, motivated team meant staff across all roles worked well for the benefit of patients.

The provider delivered services through 3 divisions: clinical operations, non-clinical operations, and retail. The senior team facilitated a “1 team” culture that promoted equity and recognition across all staff roles. This was particularly important for volunteers who led fundraising efforts in the context of the organisation’s charity status. While this element of the provider’s work is outside of our regulation, it demonstrably contributed to a unified, collaborative culture.

Staff showed pride about their work and the organisation. The provider used a recognition programme that rewarded excellence when they received positive feedback from patients, colleagues, and stakeholders.

Staff described the board of trustees as “highly responsive.” The said they appreciated the board’s willingness to challenge practice as part of continuous improvement and their openness to approving requests for new equipment that helped expand the scope of care. For example, staff request more video laryngoscopes in airway packs following an increase in their use.

The provider had been awarded gold status in the national Investors in People scheme and had a range of approaches to promote staff wellbeing. This included working with 2 chaplains, facilitation of a cross-departmental health and well-being group, and strict use of a fatigue policy. The fatigue policy required staff to have 11 hours minimum rest between shifts. In addition, a Freedom to Speak Up (FSU) guardian was in place and the service was recruiting for FSU champions. Overall, this reflected the provider’s considerable efforts to look after staff and make sure they were a responsible, motivational employer.

Governance

Outstanding ☆

Emergency and urgent care

Leaders operated highly effective governance processes, in the service and with partner organisations. Governance was measured quantitively and qualitatively and the service had a track record of quality assurance as a result. 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.

Until February 2022 the provider delivered care under the registration of an NHS trust. Following the transition to independent operations in April 2022, the service established its own clinical governance systems. The SLT, supported by 10 trustees who formed the Board, had developed the governance structure to be highly specialised, well-structured, and forward-thinking in its ability to assess performance and deliver quality assurance.

Alongside the Board, 4 sub-committees led specific aspects of governance, such as the audit and risk committee. Sub-committees had structured roles with clear impact on standards of care and operation. Governance committees were multidisciplinary and included clinical staff as good practice.

The senior team had a full understanding of the interaction between the different regulators to which the service was accountable. For example, staff were required to work within safety regulation set by the Civil Aviation Authority in addition to their responsibilities in healthcare. The senior team mapped compliance between organisations and always chose the highest standard of practice. They had a clear understanding of the areas of governance which applied to regulated activity and audits, staff training, and risk management provided continual assurance of high standards. The service had a significant track record of good outcomes, with no avoidable safety incidents, harm to patients, or complaints.

The service worked extensively and proactively with other organisations and stakeholders to implement joint governance procedures. Staff designed these to ensure patients with the most complex needs were assured of effective collaborative working. For example, the service had hosted the child death team of an integrated care board to discuss how they could work together in instances where staff found safeguarding concerns. This led to more consistent working practices by routinely including the provider at regional meetings.

The provider used an electronic system to track legal requirements for aircraft and vehicles, including for insurance and tax. This provided staff operating the vehicles with assurance they were doing so in line with national requirements.

Management of risk, issues, and performance

Leaders and teams used systems to manage, assess, and improve performance effectively. They identified relevant risks and issues and identified actions to reduce their impact. Risk management was holistic, and the service had extensive, tested plans to cope with unexpected events. Staff contributed to decision-making to support consistent quality of care.

The SLT had a comprehensive focus on managing risk relating to the various aspects of the service. For example, most risk in relation to the provider's regulated activities occurred on board aircraft and in rapid response vehicles. However, the provider considered risks across the whole operation and reflected this in high standards of risk management in non-clinical areas, such as the airside operations area and in fundraising shops operated by volunteers. As part of this approach, the provider's risk register operated across all locations and functions. Key risks for the Strensham airbase included safety around the helipad and visitor access. Each member of the SLT held responsibility for 1 of 9 sub-registers, which provided a structure for managing the risk assessment associated with each item on the main risk register.

The SLT reviewed and updated risks in real time during clinical operations meetings. This was a well-designed process that avoided potential inaccuracies associated with remote interpretation of risks. The clinical standards committee (CSC) reviewed active risks every 3 months and held the senior team to account in their management and mitigation. This system ensured an appropriate range of individuals had good understanding and knowledge of risk oversight.

The lead trustee for safeguarding, 2 trustees, the medical director, clinical operations director, CEO, head of quality and compliance, registered managers, head of clinical operations, and company secretary made up the CSC. Part of their work was to develop wider resilience with NHS ambulance services to ensure consistent coverage of the region.

Staff worked with hospital colleagues to promote good safety standards at helipads. This helped manage the risk of injury to hospital staff unaccustomed to working around aircraft. The provider worked with senior hospital counterparts to encourage the presence of trained fire marshals whenever a helicopter landed and to provide porters with health and safety training.

Business continuity plans were well developed and practised. The provider made all SOPs, management, and operations systems available remotely, which meant the SLT could continue to run the service in the event of a major incident. The provider had a service level agreement with a nearby airport that would be used as a base in the event the airbase was unusable. Similar protocols were in place to ensure the service would continue in the event of an interruption to the fuel supply, adverse weather, vehicle collisions, and manufacturer recall of equipment or vehicles.

The clinical operations management team was responsive to demands and challenges and sought to intuitively identify emerging threats or opportunities for improvement in advance. The team managed all clinical operations activity and a series of standard agenda items across planned meetings, including risk management, learning, and event reporting.

The risk management system for vehicles was extensive and included safety monitoring above and beyond that required by manufacturers and insurers. For example, the service changed a vehicle's headlights when staff noted they were dull despite being within the safety margins for the vehicle. This reflected a continuous, embedded focus on safety.

The trauma risk management team maintained extensive up to date knowledge of the trauma and emergency care capabilities of every hospital in the service's area. This meant crews could contact the most appropriate specialist centre to discuss patient transfer.

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.

Electronic information systems were integrated across the organisation's functions and meant the SLT had effective decision-making processes. The provider had a holistic, 'whole view' of the organisation's performance both at a high level and at granular detail such as by individual member of staff.

The provider used its wide range of data collection and monitoring systems to develop and implement a range of quality standards and self-assessment tools. Framed in the context of their regulatory responsibilities, the SLT measured quality using a range of clinical and non-clinical tools.

The SLT consistently submitted data to external organisations, such as statutory notifications. They used the information internally for quality improvement.

All staff followed good data protection and confidentiality standards, supported by the provider's policies. A data protection officer and information governance manager led these standards and monitored compliance.

All staff undertook information governance and cyber security training. As the provider introduced more technology to operational and care systems, the senior team updated information security training and worked with contractors to make sure patient information was secure and managed in a way that reflected their policies.

The provider had completed a 5-day General Data Protection Regulations (GDPR) compliance audit in April 2024. The results were pending and the SLT planned to use the results to ensure information governance systems worked effectively.

Engagement

Leaders and staff actively and openly engaged with patients, staff, contracting organisations, and other providers to plan and manage services. They collaborated with partner organisations to help improve services for patients. This approach demonstrably led to high quality care.

The provider's "1 team" approach to delivering care and services meant staff across all departments were engaged with each other.

The provider proactively engaged with regional health and care services to promote the advanced treatment options available. This reflected the team's work to improve knowledge of air ambulance care and provide patients with more options for lifesaving treatment.

Patient liaison leads were leading a patient experience and engagement plan; a highly targeted programme of engagement with patients and their relatives to manage care and needs after treatment. This reflected the complexities of trauma care and meant patients had time and space to speak with staff about their experiences in a therapeutic way. The team met with patients in hospital and at home and planned this with others involved in their recovery. Staff worked with mental health colleagues to assess the potential benefits of meeting with patients living with mental health conditions to ensure this was appropriate.

There was an ethos of empowerment at all levels in the provider designed to capture good ideas and translate them into better ways of working and good patient outcomes. The senior team supported staff to develop working groups within the organisation to test ideas and deliver them to completion. This was part of a supportive, exploratory environment that facilitated learning and development.

A welfare support team provided on-demand support to staff following traumatic events.

The service participated in a national forum of air ambulance colleagues. This was a collaborative approach to sharing challenges and solutions. For example, staff worked with others in the forum to strategise their response to a national shortage of ketamine.

The patient liaison leads contacted 204 patients as a result of aftercare referrals in the previous 12 months and sought feedback from 174 individuals following an assessment of the appropriateness of seeking feedback from them.

The service asked clinical observers for feedback on their experience as an additional measure of crew professionalism and practice. Feedback was consistently good, with observers rating crews highly for communication, professionalism, and the value of the experience.

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 were focused on piloting and implementing technology-led innovation and participation in trials with other organisations.

The senior team had a considerable focus on technology and innovation as part of their strategy to provide care and services at the leading edge of the sector. For example, the SLT were monitoring the types of missions transferring patients from the scene of incidents to hospitals to assess the viability of a night air service. This would require substantial investment in night flight vision technology and training and the team wanted to make sure it would provide sufficient benefits to patients before implementation.

The senior team had tested and implemented a new electronic governance, risk management, and operations platform that digitised most management aspects of the service. This included audits, vehicle maintenance, incident management, and live risk assessments. Staff were contributing to the embeddedness of the system and providing real time feedback to the senior team to help ensure the system offered the adaptability and support they needed.

Staff had a demonstrable ethos of curiosity and collaboration when exploring new ways of working and new opportunities. For example, the service had engaged with patient safety teams from NHS England and other regional NHS services to strategise effective implementation of the patient safety incident reporting framework (PSIRF). The team had developed an innovative approach to patient safety development by pooling cross-organisational safety knowledge to help staff from different services share learning. This was particularly useful in a clinical environment so focused on life-saving care and treatment. In another area of work, patient liaison leads had developed, tested, and implemented a new strategy to make sure patient engagement was focused on those who would most benefit based on existing evidence of how patients who experienced life-threatening events recovered. Such examples demonstrated the approach of the team to ensure work and projects were evidence based.

Staff often operated vehicles in challenging environments and scenarios that presented risks to the general public. The team were acutely aware of this and worked together and with emergency services to reduce risk when they were delivering care and treatment. For example, pilots found members of the public often tried to give them cash as a donation to the charity. To reduce the risk of members of the public approaching the helicopter and still enable them to donate, the provider placed a QR code on the side of the aircraft that provided an online donation link to anyone in range.

The provider had participated in the European HEMS Benchmarking Project with a similar air ambulance service in Denmark. This was an international benchmarking and best practice collaborative that helped similar organisations learn from shared challenges. The team prepared detailed, structured learning from their participation and were working with colleagues to implement them in a UK context.

The head of education and training was leading a project to install an immersive training simulator at the airbase as part of a wider programme of refurbishment. This reflected the value the provider placed on both educational development and innovation and included provision to carry out research on the impact of training before and after simulation exercises.

Outstanding ☆

Emergency and urgent care

The provider had an innovation proposal process that empowered staff to submit ideas and project plans for consideration. The process enabled staff to view all information associated with progress as it was reviewed through various internal channels.

Reflecting the provider's focus on collaborative working, staff met with counterparts from 3 other air ambulance providers as part of the development of a peer review process. This would complement the existing self-assessment framework and was designed to give a better understanding of quality.

Staff completed 'learning from excellence' reports to acknowledge the action of people involved in saving lives during call outs. For example, where members of public had helped save a person in danger and where a student paramedic had acted quickly to use a public automatic external defibrillator. This helped to embed the service in communities and aimed to give people confidence in emergency situations.

The SLT recognised the pressures on the service, particularly in relation to the charity status of the organisation. They had commented an organisational resilience project aimed at sustainability to ensure people could depend on the service well into the future.