

Essex & Herts Air Ambulance Trust

Essex and Herts Air Ambulance Trust

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Essex and Herts Air Ambulance Trust is operated by Essex and Herts Air Ambulance Trust. The trust is a charity and provides a helicopter emergency medical service (HEMS) for critically ill and injured patients in Essex, Hertfordshire and surrounding areas. A team of pre-hospital doctors and critical care paramedics deliver emergency medical care. Clinical staff travel by either helicopter air ambulance or by rapid response vehicles (RRVs) during times of diminished natural light. Pre-hospital emergency medicine focuses on caring for seriously ill or injured patients in urban, rural, or remote settings before they reach hospital, and during emergency transfer to hospital or between hospitals.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 February 2018, along with an unannounced visit to the service on 13 February 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this service was urgent and emergency care.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were effective processes in place to report, record and share learning from incidents.
- Staff were clear in their responsibilities to safeguard children and adults from abuse.
- The service had effective processes in place to protect patients and staff from healthcare associated infections. Vehicles and equipment had been regularly maintained and serviced.
- Patient care was evidence based and recognised best practice.
- Thorough induction processes ensured staff were knowledgeable and competent in their role.
- Patient feedback was positive. Staff treated patients with dignity, respect and compassion.
- Advanced planning ensured the service was delivered to meet the needs of the local people.
- Patients could access the service in a timely manner, in conjunction with the local NHS Ambulance service.
- The service had a clear leadership structure in place. Leaders were experienced, knowledgeable and passionate to provide excellent care to patients.
- Staff feedback consistently showed senior leaders to be supportive, visible and approachable.
- There was an effective governance framework in place. Death and disability meetings gave clinical and managerial staff regular opportunities to reflect and share learning from previous missions and incidents.
- All staff reported the presence of an open and transparent culture within the service. Staff described colleagues as 'family' and that they felt supported by senior management.
- The service demonstrated a range of plans to sustain and improve the service through a number of innovative methods.

Summary of findings

Heidi Smoult

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Emergency and urgent care services

Rating Why have we given this rating?

The main service was the provision of urgent and emergency care to critically unwell or injured patients by a team of experienced clinicians who delivered pre-hospital emergency medicine. Patient transportation took place by air or land ambulance, dependent on clinical need.

There were effective processes in place to identify, report and learn from incidents. We found medical records to be complete, legible and reflective of the care and treatment provided. Safety was a key focus for the service. Pertinent risk assessments were completed, with effective leadership and governance processes in place to monitor and oversee the risk to both staff and patients.

Essex and Herts Air Ambulance Trust

Detailed findings

Services we looked at

Emergency and urgent care

Detailed findings

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Background to Essex and Herts Air Ambulance Trust

Essex and Herts Air Ambulance Trust is operated by Essex and Herts Air Ambulance Trust. The service opened in 2007. It is an independent air ambulance service in North Weald, Essex. The service primarily serves the communities of Essex and Hertfordshire.

The charity was established in 1997 under the name of Essex Air Ambulance. In April 2007, the charity became

the Essex and Herts Air Ambulance Trust (EHAAT). The North Weald air base is one of two locations within the service and is home to one air ambulance helicopter and one rapid response vehicle (RRV).

The service has had a registered manager in post since July 2011.

The announced inspection took place on 6 February 2018, with an unannounced inspection on 13 February 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Facts and data about Essex and Herts Air Ambulance Trust

The service provides urgent and emergency treatment to critically ill and injured patients in Hertfordshire, Essex and surrounding areas.

Clinical and managerial staff worked at both locations within the service. Critical care paramedics (CCPs) were directly employed by the service and seconded from the local NHS ambulance trust. Doctors specialising in pre-hospital emergency care, covered shifts on a regular basis, through agreement with their primary employing NHS trust.

The service did not have an accountable officer for controlled drugs. The registered manager was the named medicines lead for the service.

The service is registered to provide the following regulated activities:

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

Detailed findings

During the inspection, we visited the service's airbase in North Weald, Essex. We spoke with 12 staff including; registered critical care paramedics and management. We were unable to speak with people who use the service during our inspection due to the nature of the service, providing emergency treatment and transport for critically injured or ill people. Therefore, we reviewed a selection of patient and family feedback during the inspection process. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in February 2014, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (1 January 2017 to 10 January 2018)

- In the reporting period 1 January 2017 to 10 January 2018, the service mobilised 894 missions by air and 218 missions by use of rapid response vehicle. The most common type of call was medical illness and road traffic collisions.

Eight pilots and co-pilots, six pre-hospital care doctors and 14 critical care paramedics (CCPs) worked at the service.

Track record on safety:

- No Never events
- From the period of 1 January 2017 to 29 January 2018, there were 84 clinical and non-clinical incidents reported. Incident data relates to both locations within the service (North Weald and Earls Colne airbases).
- No serious incidents
- No complaints

Emergency and urgent care services

Safe

Effective

Caring

Responsive

Well-led

Overall

Information about the service

The main service provided by this ambulance service was the provision of emergency and urgent care by air ambulance and rapid response vehicle.

Summary of findings

We found the following areas of good practice:

- There were effective processes in place to report, record and share learning as a result of incidents and safeguarding concerns.
- Senior managers ensured that staff had received mandatory training to enable them to carry out their role safely and effectively.
- The service had effective processes in place to protect patients and staff from healthcare associated infections. Vehicles and equipment had been regularly maintained and serviced.
- Medicines were stored securely and regularly monitored by senior staff.
- Patient report forms were complete, accurate and stored securely.
- Patient care was evidence based and recognised best practice. Clinical managers encouraged staff to participate in research and share learning with other healthcare related organisations.
- Patient care was planned and delivered in accordance with a wide range of policies and standard operating procedures.
- Staff completed dynamic risk assessments to provide tailored care on an individual basis, according to patient need.

Emergency and urgent care services

- Thorough induction processes ensured staff were knowledgeable and competent in their role. Staff worked with other organisations both at the scene of incidents and through regular meetings to facilitate effective multi-disciplinary working.
 - Patient feedback was consistently positive. Staff treated patients with dignity, respect and compassion.
 - The service had identified some patients had unanswered questions after treatment. In response, the new 'patient liaison manager' role enabled face-to-face contact with clinicians to discuss questions around previous episodes of care.
 - The service actively supported staff through regular welfare checking and providing an open and supportive environment.
 - Services were planned and delivered to meet the needs of the local people. Patients could access the service in a timely manner, in conjunction with the local NHS Ambulance service.
 - The service was meeting the individual needs of patients through various methods, including but not limited to; language line and dementia and learning disability training.
 - The service had a clear leadership structure in place. Leaders were experienced, knowledgeable and passionate to provide excellent care to patients. Staff feedback consistently showed senior leaders to be supportive, visible and approachable.
 - Staff demonstrated the service's visions and values through the course of their work.
 - There was an effective governance framework in place. Death and disability meetings gave clinical and managerial staff regular opportunities to reflect and share learning from previous missions and incidents.
 - All staff reported the presence of an open and transparent culture within the service. Staff described colleagues as 'family' and that they felt supported by senior management.
- The service actively sought engagement from internal and external staff and the public through a vast range of methods.
 - The service demonstrated a range of plans to sustain and improve the service through a number of innovative methods.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- There were processes in place to ensure the effective reporting, recording and sharing of incidents to aid learning.
- Incident reporting was part of mandatory training for all staff. At the time of our inspection, 100% of staff had received this training. We spoke with two staff who both described the incident reporting system in use and confirmed incident debriefs routinely took place following the reporting of incidents.
- Staff had access to a newly implemented electronic incident reporting system (November 2017). Senior managers and clinical staff received information on all reported incidents by email. The new system ensured that incident information sharing with staff in a timely manner, by computer, mobile phone or tablet device. This allowed effective oversight from senior managers within the service and identified possible themes or trends at the earliest opportunity.
- Essex and Herts Air Ambulance trust (EHAAT) reported no serious incidents or never events from February 2017 to January 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- For the period of 1 January 2017 to 14 November 2017, there were 57 clinical and non-clinical incidents reported. From 15 November 2017 to 29 January 2018, there were 28 clinical and non-clinical incidents reported. Incident data related to both locations within the service.
- The new incident reporting system enabled staff to differentiate which location incidents related to within the two locations in the service. From 15 November 2017, to 29 January 2018, the North Weald airbase reported 18 clinical and non-clinical incidents.
- We reviewed three incident report forms. Incident reporting took place in a timely manner, with thorough investigations detailing key findings and action plans. Action plans demonstrated clear ownership and completion dates.
- Staff confirmed that they received regular feedback from incidents. This occurred either face to face or by email, in addition to regular discussion at monthly clinical governance days and during the daily brief.
- We saw examples of learning from previous incidents. Staff told us about various changes to procedures after incident reporting. This included changes to equipment, medicines management and cleaning processes.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify a patient (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff had electronic access to a policy named 'Being Open with Patients & Duty of Candour'. We reviewed the policy and saw it provided clear guidance for staff on the duty of candour.
- Staff did not receive specific training on the duty of candour however; regular discussion took place around this subject at weekly death and disability meetings and at clinical governance days. We spoke with two staff who were able to tell us what the duty of candour meant and its application, if required and confirmed receipt of training named 'being open'.
- The service monitored performance around the duty of candour which was a specific key performance indicator, discussed at monthly pre-clinical governance day team meetings and at regular board meetings.
- Decision making for or against the use of the duty of candour was not formally recorded. We raised our concerns with the registered manager. At our unannounced inspection, we found that the service had acted on our concerns and was recording discussions which were also referenced on the electronic debrief records where previous missions were reviewed.
- Incidents formed part of regular discussion at bi-monthly meetings. We reviewed a sample of meeting

Emergency and urgent care services

minutes, which demonstrated a broad range of attendance from clinical staff to senior managers within the service. This ensured that staff received feedback from incidents.

- In December 2017, the service introduced a monthly safety committee meeting. The terms of reference demonstrated emphasis on the meeting to provide detailed discussion around safety incidents. A review of meeting minutes demonstrated a selection of incident reviews had taken place, with staff allocation of actions from the meeting. Staff were invited to attend meetings so open discussion and learning from incidents could take place.
- The service maintained regular contact with the local NHS Ambulance trust to ensure multi-agency incident investigation. Designated members of staff reported incidents to the local NHS ambulance trust to ensure the sharing of investigation and learning.

Mandatory training

- There were effective processes in place to monitor, schedule and deliver mandatory training.
- The human resources (HR) department and senior staff maintained oversight of mandatory training compliance with the use of a red, amber and green (RAG) rating system. We reviewed the spreadsheet which clearly demonstrated when training had taken place and when refresher training was due.
- Staff received blue light driver training from their primary employer. The human resources department held records of training.
- Staff received comprehensive training on a number of subjects including but not limited to; accident and incident reporting, fire safety, conflict resolution, controlled drugs and records management.
- At the time of our inspection, information provided by the service showed that the mandatory training target was 100% and compliance was 100% in all subjects. The mandatory training programme was on a rolling basis.
- All paramedics had received advanced training in critical care and held recognised qualifications.

Safeguarding

- There were effective processes in place to safeguard people from abuse.
- The registered manager was the safeguarding lead and was available to provide advice in the event of safeguarding concern being identified. In addition, the service's base location provided further safeguarding support from the designated clinical manager on site.
- Staff received level three safeguarding children and safeguarding adults training. This complied with the Safeguarding children and young people: roles and competencies for health care staff intercollegiate document 2014. At the time of our inspection, compliance with training was 100%.
- We spoke with two members of staff who could clearly give examples of safeguarding concerns and the reporting processes in place.
- Pilots did not receive safeguarding training, as they did not have face-to-face contact with patients and relatives. However, all pilots were required to read the service's safeguarding policy to ensure understanding of this subject.
- Safeguarding policies and procedures referenced recent legislation. The policy and procedure outlined what constituted a safeguarding concern and gave examples of various types of abuse. Information technology devices allowed staff to access policies and procedures remotely.
- Staff received specific training in recognising domestic violence. At the time of our inspection, 100% of staff had received this training.
- Crews accessed a single point of contact telephone line through the local NHS ambulance trust to make all safeguarding referrals to the local authority. This enabled safeguarding concern reporting to take place in a timely manner, with feedback of safeguarding outcomes from the local NHS ambulance trust where applicable.
- Staff told us that existing knowledge of safeguarding concerns was from the critical care desk, upon mobilisation to an emergency if available. The critical care desk was located in the local NHS ambulance

Emergency and urgent care services

trust's emergency operations centre. Due to the nature of calls, information was not routinely available; however, safeguarding concerns were shared with the local NHS ambulance trust.

Cleanliness, infection control and hygiene

- The service had effective processes in place to protect people from healthcare associated infections.
- The service had an infection, prevention and control (IPC) policy that was within review date. The policy cross-referenced other associated policies such as the uniform policy and included advice and guidance for staff to follow including hand hygiene, the use of personal protective equipment (PPE) and sharps injuries.
- The base location had a named infection prevention and control (IPC) lead.
- The aircraft, rapid response vehicle (RRV) and base location were all visibly clean and well organised.
- The sluice room was clean and tidy. All cleaning equipment was colour coded to indicate correct areas for use, for example; clinical or non-clinical areas.
- Staff had access to shower facilities at the service's base location. In addition, washing machines and drying cabinets were onsite to allow for the washing and decontamination of heavily soiled uniform, in line with the service's IPC policy.
- The aircraft and RRV contained personal protective equipment to protect staff, prevent and control the spread of infection. Observations revealed that gloves, aprons, facemasks, cleansing wipes and hand gel were available on both vehicles. Staff carried gloves, aprons and facemasks and we observed staff using these when providing clinical care.
- Clinical waste was clearly segregated in colour-coded bags. Clinical waste bins were securely locked. Sharps (needles) were safely stored in a locked bin. All sharps containers were dated and signed upon assembly. Guidance for sharps management was on display to provide information and guidance to staff.
- Blankets were single use to prevent and control the spread of infection.

- The service had a contract in place for the deep cleaning of both the aircraft and RRV. Internal deep cleans took place on a quarterly basis with monthly exterior cleans on both the aircraft and RRVs.
- We reviewed deep cleaning records and saw that cleaning had taken place as per schedule.
- Staff cleaned the aircraft after each episode of patient care. In addition, staff completed a weekly clean of the aircraft and RRV.
- Staff carried out weekly audits of cleanliness relating to the interior and exterior of the aircraft and RRV. Data from 1 January 2017 to 8 January 2018 demonstrated overall average compliance at 99.7%. Non-compliance was attributed to specific areas including cleanliness of aircraft skids and helicopter exterior. However, these areas were due to environmental factors, meaning the use of water would increase the risk of ice on the aircraft.
- Weekly cleanliness audits of the RRV checked the cleanliness of both the exterior and interior of the vehicle. From January 1 2017 to January 8 2018 showed overall compliance at 98.7%. Non-compliance was attributed to adverse weather and winter driving conditions relating to the exterior of the vehicle.
- Senior managers quality assured all IPC audits to ensure data collection was an accurate reflection of cleanliness.

Environment and equipment

- The base location was suitable for the needs of staff and for the purpose of work that was carried out. Systems and processes ensured equipment had been serviced and maintained on a regular basis.
- Facilities included but were not limited to; an aircraft hangar, crew area, staff restroom, lecture suite, training room, equipment room and controlled drugs room.
- The aircraft and rapid response vehicles (RRVs) were locked in a secure hangar when not in use. Vehicle keys were securely stored in a locked cupboard.
- Swipe card access secured the site. During our inspection, we saw that all areas were secure preventing access to unauthorised personnel.

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- The aircraft hangar was free from clutter and well organised. Floor markings clearly depicted a designated path to ensure safety in areas of vehicular movement.
- There were effective processes in place to ensure that equipment was regularly maintained, clean and ready for use in the event of an emergency. The service kept a spreadsheet of equipment maintenance and calibration dates. Servicing had taken place at regular and recommended intervals.
- The operational director had overall responsibility for the fleet with the servicing and MOT managed by the clinical operations manager. There were service level agreements (SLAs) in place for each vehicle type with designated maintenance schedules. The vehicle leading dealerships sent reminders when maintenance was due. We reviewed the RRV servicing records and found all to be in order. Both vehicles had valid tax and MOT in place.
- The service acquired a new helicopter in August 2017 after a three-year fund raising project. Air ambulance servicing was undertaken by the company providing this service.
- Staff carried out a daily vehicle inspection on the RRV. Electronic check sheets ensured completion of checks. Compliance with checking processes was overseen by senior managers. We reviewed records that demonstrated vehicle checks had taken place on all days prior to our inspection over the previous three months.
- All aircraft checks took place prior to the commencement of shift by the pilot and co-pilot. We saw the standard operating procedure allocated protected time prior to aircraft mobilisation to ensure that staff had adequate time to complete all required safety checks.
- Stock replenishment took place at the base location. We saw that there was an adequate amount of consumable items, spare batteries and other equipment to allow for replenishment of stock. Effective systems were in place to replenish consumable supplies using pre-assembled kits. Stock rotation occurred to ensure all equipment was within the use-by date.
- We looked at all equipment and found there was the appropriate range of paediatric and adult equipment, in various sizes. All equipment was clearly marked and separated according to size.
- All consumable equipment was in date, with packaging intact where applicable. Storeroom areas were tidy and well organised.
- All equipment within the RRV and aircraft was safely secure. During flight, restraint systems meant equipment bags were secured with straps to prevent movement and possible injury to either the patient or crew.
- Staff had access to a wide range of training equipment such as ultrasound machines, cannulation, resuscitation and casualty simulation manikins and intraosseous infusion training equipment. The dedicated training room contained a wide range of training equipment. This was clearly marked to ensure staff did not use this equipment operationally.
- Staff reported faulty equipment via the service's internal electronic incident reporting system. A review of incident report showed equipment faults had been reported and acted upon in a timely manner.

Medicines

- Medicines were stored safely and monitored effectively through internal systems and processes in place.
- The service stocked and used controlled drugs (CDs). There was no controlled drugs accountable officer in post as this is not a regulatory requirement for the type of service. However, the registered manager was the medicines lead for the service.
- The service had a medicines policy in place. This reflected current practices in medicine such as ordering, storage and disposal. The policy was based on up to date information and recent legislation and guidance.
- A local NHS hospital trust supplied the medicines under a service level agreement (SLA).
- Staff routinely checked all CDs on the commencement of shift. This ensured that drug pouch contents matched recorded amounts. CDs stored within the double locked cabinet were reconciled with drug registers on a daily basis.

Emergency and urgent care services

- Medicines were stored securely at the base location.
- We checked CD records. We saw that all CDs had been checked on a daily basis, with two members of staff present. In addition, all stock from the store tallied with the recorded amounts in the CD register.
- We checked three controlled drugs against the register and found them to be correctly stored and recorded.
- CDs were stored securely within the aircraft and rapid response vehicle at all times during our inspection. Crews maintained possession of controlled drugs pouches at all times when the aircraft or rapid response vehicle was not in direct sight. Drug pouch tags ensured immediate identification of tampering.
- CDs were double-checked prior to administration. We saw staff adherence to this process during our inspection. Two members of staff had received training as authorised witnesses for the destruction of CDs. The pre-hospital care standard operating procedure provided staff with clear guidance on the destruction and documentation process to ensure compliance with law.
- Refrigerated medicines were stored safely in a locked fridge with access for authorised staff only. Monitoring of fridge temperatures took place on a daily basis. A review of checks demonstrated that fridge checks took place every day from 1 November 2017 to 6 February 2018.
- We checked medicines within the fridge. All were in date.
- On a bi-monthly basis, the clinical manager completed an audit of fridge temperatures. Audit data demonstrated appropriate actions in the event of anomalies, such as contact to the local NHS medicine supplier for advice and to ensure the maintenance of the integrity of medicines.
- Medical gases were securely stored in a suitable locked cabinet. Appropriate signage was in place to warn staff and visitors that combustible gasses were held in his area. There was clear separation of full and empty cylinders. All medical gases were in date. Medical gases were secured appropriately for transport in both the RRV and aircraft.
- The service had recently moved to a prefilled syringe system of administration for some medicines supplied

by the local hospital as this reduced the time from administration on scene and ensured dosage accuracy. Medicine administration documentation was present in the patient's medical record.

- There was a system in place to action medicine safety alerts and emails.

Records

- Systems and processes ensured the secure storage of medical records. Records were legible, accurate and comprehensive.
- Staff completed electronic patient report forms (PRFs) using either a tablet or computer with secure medical records storage on a cloud storage system. This enabled the secure holding of patient information and access to records in an efficient and timely manner.
- The clinical director reviewed all PRFs weekly to ensure the consistency and accuracy of data recording.
- Information technology systems in use allowed managers to perform regular audits of PRFs.
- Anonymised PRFs, used at debrief sessions and case studies ensured the protection of patient confidentiality.
- Due to the nature of service provided, crews did not routinely have access to special notes. All information held was passed from the local NHS ambulance trust at time of mobilisation.
- The service stored previously used paper PRFs securely in a locked room at the service's headquarters.
- Staff completed PRFs and provided the receiving hospital with a printed copy. This ensured hospital staff had access to a record of clinical observations and treatment provided prior to arrival at hospital.

Assessing and responding to patient risk

- Crews had access to enhanced clinical advice at all times. A designated consultant provided assistance by telephone in the event that clinical advice was required. Advisors also attended the weekly death and disability meetings, which enabled retrospective reviews of previous missions.

Emergency and urgent care services

- Staff assessed whether patients triggered the locally developed trauma triage tool (TTT) to determine the receiving hospital. TTT positive patients were usually conveyed to the nearest major trauma centre and if negative, to a trauma unit based in a local hospital.
- Patient report forms contained clinical observations to allow for early detecting of deterioration. Observations included; blood pressure, oxygen saturation, level of consciousness, pulse rate and respiratory rate.
- A selection of 10 PRFs showed a recorded Glasgow Coma Scale (GCS) in all cases. The GCS allows a clinician to carry out an assessment for impairment in conscious levels.
- Prior to departure from scene, the critical care paramedic and doctor carried out a verbal risk assessment named 'what if'. This was to ensure that in the event of clinical deterioration, for example, dis-lodging of an endotracheal tube (a tube which is inserted into the airway to establish and maintain patency), to ensure access to the relevant equipment in a timely manner during flight.
- The service provided a number of standard operating procedures (SOPs) for the treatment of specific conditions and injuries such as potential sepsis and open fractures.
- There was no specific exclusion criteria in use. Staff explained that each patient was dynamically risk assessed on a case-by-case basis, including environmental and clinical risk assessments.
- Staff had access to a policy named analgesia and sedation. The policy was in date and cross-referenced the local standard operating procedure for pre-hospital emergency anaesthesia. The policy provided clear guidance for staff on the use of analgesia, labelling of medicines and range of clinical scenarios for the use of sedation and analgesia. The SOP contained recommended actions in the use of light anaesthesia to restrain disturbed or violent patients who may be at risk of causing harm to themselves or others.
- Staff had received training in conflict resolution. At the time of our inspection, 100% of staff had received this training.
- Staffing was planned in advance to meet the needs of the service. Clinical and non-clinical staff worked at both airbases operated by the service.
- The service employed five whole time equivalent (WTE) critical care paramedics (CCPs) who undertook dual roles as clinical managers, patient liaison managers and an operational manager. There were also nine WTE CCPs seconded for a period of three years duration from the local NHS ambulance Trust making 14 CCPs on the rota, which covered both airbases.
- Dual role working ensured staff flexibility to meet the demands of the service.
- The service aimed to have six WTE pre-hospital care doctors on secondment from teaching hospitals for a period of nine months on a rotational basis. At the time of our inspection, there were five doctors seconded with additional shifts filled by emeritus doctors. Emeritus doctors are experienced staff that have retired from active medical practice and maintain competencies on a regular basis. Five experienced medical consultants also undertook regular shifts and provided mentoring, training and governance expertise.
- The service did not use agency staff. Support was through a team of committed emeritus doctors who maintained their competencies by undertaking regular shifts and attending clinical governance events.
- Staffing was suitable to meet the demands of the service. A review of rotas demonstrated that all shifts had an allocated CCP and doctor.
- The seconded CCPs also led the critical care desk at the local NHS ambulance Trust. This ensured that appropriately trained staff, with relevant knowledge, tasked missions to the air ambulance appropriately.
- The service recognised the recruitment of doctors as a key challenge. Doctor recruitment took place up to 18 months in advance to secure staff with the appropriate skills for the role. To ensure adequate staff, the service had recently embarked on the provision of a dedicated recruitment pathway with a local NHS Trust.
- The service was working towards accreditation for Pre-hospital Emergency Medicine (PHEM) Doctor training status. This provided a further route for doctor recruitment.

Staffing

Emergency and urgent care services

- The trust placed emphasis of ensuring staff were competent at carrying out dual roles. Therefore, in the event of staff being required, they were able to call on their own team for clinical work at short notice, due to sickness or other unavoidable circumstances.
- Shift coverage was monitored through a key performance indicator (KPI), overseen by senior management. For the months of October 2017 and November 2017, KPI data reflected that 100% of shifts were covered.
- We reviewed sickness rates for staff within the service, which was low. Records demonstrated that two days sickness had been lost from January 2017 to December 2017.

Anticipated resource and capacity risks

- The service's business continuity plan was in date and contained information for staff in the event of an occurrence that threatened business continuity.
- Daily briefs covered thorough weather forecasting to ensure aircraft safety prior to flight. The pilot made the final decision to fly. In the event that the aircraft unavailability, clinical teams used the rapid response vehicle to respond.
- Staff demonstrated in depth knowledge of which speciality services surrounding hospitals offered. This meant staff could alert receiving units to incoming patients to ensure capacity.

Response to major incidents

- The service had an in date business continuity plan in place. The document demonstrated there were clear lines of responsibility and guidance in the occurrence of events that may stop or interrupt normal business.
- The aircraft and rapid response vehicle carried a major incident folder. This provided guidance for staff in the event of attendance at a large-scale incident.
- The service worked with the local NHS ambulance service and other emergency services to plan and carry out major incident exercises. The last major incident took place in 2015, with a further training event planned for 2018.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Staff adhered to various standard operating procedures in use, including treatment pathways such as rapid sequence induction (induction of anaesthesia and advanced airway management) and spinal immobilisation. Wide ranges of SOPs were available to guide staff and accessible electronically.
- Staff had access to an SOP to treat potential sepsis and open fractures. Staff had access to antibiotics if clinically indicated.
- SOPs were based on National Institute for Health and Care Excellence (NICE) or Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.
- We reviewed a selection of policies and SOPs and saw they were within their review date with specified reviewed dates to ensure regular review.
- Distribution of policy changes was via email. Staff acknowledged receipt and read any changes with use of electronic signature. An automated reminder triggered after seven days, if policies staff had not responded. We saw evidence from a member of staff that this process was taking place.
- The service encouraged staff to participate in research. We saw recent research topics included hypotension post rapid sequence induction (RSI). RSI is a form of airway management to induce anaesthesia. Research papers referenced recent national guidance. Information sharing took place both internally with staff and at medical conferences.
- Staff carried out a daily review of an SOP or policy selected at random during the daily brief, prior to mobilisation. We observed a daily review of the safeguarding policy, which was based on national guidance.
- The service planned and delivered monthly clinical governance days. This enabled the sharing of best practice in line with national guidance on a range of illnesses and injuries.

Emergency and urgent care services

- All staff we spoke with demonstrated a passion to explore and learn from recent research to provide the best care possible for patients.
- The service was actively engaging with neighbouring air ambulances and was part of the Association of Air Ambulances. This enabled staff to share and learn from best practice. Regular engagement with other organisations previously led to migration to the same electronic database. This enabled the service to carry out regular audits and comparison of statistics.

Assessment and planning of care

- Patients were conveyed to the nearest, most appropriate hospital. Patient destination planning took place in advance, using information technology mapping systems which calculated journey times by either land or air ambulance. Destination depended on the clinical condition of each patient, and ensured conveyance to the most appropriate clinical facility.
- Staff accessed information to ensure that the conveyance of patients was to the nearest speciality hospital. Transfers took place to cardiac, trauma and burns centres for example, dependent on clinical need after a thorough clinical assessment at scene.
- Clinical protocols were in place to manage specific conditions such as head injury, stroke and heart attack. We saw that protocols were tailored for both adult and paediatric patients.
- Pilots regularly updated clinical staff on the access and egress from scene to ensure transportation took place in a timely and smooth manner.
- We saw that regular and comprehensive conversations took place between clinical staff and pilots. This ensured the pilot could plan air transfer in an efficient and timely manner.
- Crews had access to enhanced clinical advice at all times. A designated consultant provided assistance by telephone in the event that clinical advice was required. The daily brief ensured staff knew who the named consultant was for the shift, and that contact numbers were available.

Response times and patient outcomes

- There are no nationally specified key performance indicators for the type of service provided.

- Patient outcome information was limited due to the nature of services provided. Clinical staff would hand over a patient, and move on to the next mission, therefore not always knowing the outcome of each patient.
- In response to this, the service had implemented the role of patient liaison manager (PLM). The PLM communicated with patients and relatives after treatment, which allowed for informal feedback of patient outcomes.
- The service routinely monitored mobilisation and response times for both land and air response through use of information technology systems in place.
- The service collected data on patient outcomes, including if the patient was conveyed by air or escorted in a road ambulance, if the crew assisted on scene, recognised life extinct or conveyed the patient by air to the most appropriate receiving unit.
- The service monitored the number of clinical procedures carried out, such as pre-hospital emergency anaesthesia. This allowed the service to ensure that appropriate equipment was available to achieve the best patient outcomes possible.

Competent staff

- Staff had the appropriate skills and knowledge to deliver effective care and treatment. There were robust processes in place to ensure recruitment of staff with adequate experience. The human resources department maintained records of employment contracts, disclosure and barring service (DBS) checks and employee history.
- Upon commencement of employment, staff received an induction. This focused on introduction to various clinical and non-clinical teams, information technology systems and health and safety.
- Induction procedures were thorough to provide staff with adequate organisational knowledge. This gave staff the skills and knowledge to perform their role safely and effectively.
- New critical care paramedics (CCPs) completed a competency log. This process supported new staff with oversight from a senior paramedic. A 'pre sign off' shift allowed senior clinicians to identify any learning needs

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prior to final assessment. We reviewed a log and found evidence of further staff support at three, six and nine month intervals to identify any concerns and monitor staff welfare on a face-to-face basis.

- All clinical staff undertook a one-week course in advanced pre-hospital helicopter emergency medicine (currently 94% with three new members of staff booked to attend in March 2018) and a one-day course in advanced surgical training.
- Staff employed by the service received an appraisal on a yearly basis. Staff on secondments from local NHS ambulance service trusts received an appraisal through their primary employer, and managed by senior critical care paramedics (CCPs) within the service, in conjunction with the local NHS ambulance trust.
- At the time of our inspection, 100% of staff employed directly by the service had received an appraisal.
- The clinical director monitored appraisal completion for doctors seconded to the service. At the time of our inspection, all seconded doctors had received an appraisal within the previous 12 months.
- Staff described the appraisal process as meaningful. We reviewed a selection of completed appraisals, which demonstrated open and honest discussion had taken place between staff and line managers. The appraisal document was comprehensive in identifying and addressing training needs, aspirations and career development. The service encouraged staff to attend external training and conference events to maintain competence in their role.
- At the time of inspection, support was being provided for two CCPs to advance with master's degree courses.
- Weekly 'Death and Disability' (D and D) meetings brought staff together to reflect on previous episodes of care and suggest future changes to practice, if required. During our inspection, we observed a meeting. Discussion took place around a previous attendance to a multi-casualty incident. Senior clinicians supported staff to speak openly about changes, which could lead to improved practice.
- D and D meetings facilitated a casualty simulation exercise. We observed this taking place on the day of our inspection. Staff challenged each other on relevant guidelines and protocols by the use of simulation exercises.
- Monthly clinical governance days provided both internal and external staff with the opportunity to share best practice in line with national guidance on a range of critical illness and injury. Staff gained certification for attendance, which aided continued professional development, and the demonstration of role based competency.
- The service encouraged staff to attend monthly clinical governance meetings, and provided funding for one meeting a month, should it fall on an employee's rest day. This enabled remote workers to attend training with protected time.
- At the point of induction, the human resources department carried out driving licence checks, then subsequently at yearly intervals. All critical care paramedics and paramedic managers had received training in blue light driving with the local NHS ambulance service trust. Upon commencement of employment with the service, all CCPs and clinical managers completed a two-hour driving assessment and attended a one day advanced car handling course. At the time of our inspection, two new members of staff were awaiting this training.

Coordination with other providers

- Regular communication with other services ensured the coordination of care delivery. During our inspection, we saw staff interacting positively with other emergency services and healthcare providers.
- Bi-monthly air operational meetings ensured that the service and local NHS ambulance trust maintained regular contact to discuss matters such as equipment, operations, staffing and incidents.
- Senior members of staff regularly liaised with other air ambulance services, police, fire and other agencies and planned events, such as major incidents in collaboration with each other.

Multi-disciplinary working

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- All members of the clinical and non-clinical team worked effectively and maintained regular communication to aid multi-disciplinary working.
- The service could demonstrate regular contact with the local NHS ambulance trust to facilitate joint working.
- During our inspection, we saw regular communication between clinical staff and pilots. This ensured each member of staff had the required information to carry out their role effectively.
- The service was a member of local Trauma Networks. Major trauma networks consist of a group of services and staff, who aim to reduce death and disability following injury. This enabled the service to maintain up to date practices in care delivery along with other receiving trauma units and medical staff.
- Trauma network meetings covered a range of subjects including case studies and audits. Meetings demonstrated good attendance with a broad range of representation from various receiving hospitals.
- Co-pilots supported clinical staff whilst on scene of an incident. They assisted in carrying equipment, opening equipment bags and positioning the patient stretcher with heated blanket prior to patient transfer.
- Staff assisted the local NHS ambulance trust teams at the scene of incidents. During one mission, we saw that staff communicated effectively with the local NHS ambulance crew.
- Hospital handovers were comprehensive, providing accurate clinical information to the receiving teams.

Access to information

- Due to the emergency nature of services provided, staff did not routinely have access to 'do not attempt resuscitation orders' or special notes that provide information about a specific patient.
- If the critical care dispatch desk held relevant information, this was passed to clinicians at the point of call.
- The rapid response vehicle contained regularly updated satellite mapping systems. The aircraft was supplied and maintained by an external company and was equipped with appropriate navigation systems as advised by the Civil Aviation Authority.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service did not routinely transport patients detained under section 136 of the Mental Health Act unless there was a significant underlying illness or injury. Section 136 is an emergency power, which allows people to be taken to a place of safety from a public place if a police officer considers them to be suffering a mental illness and if they need care.
- Staff received specific training in the Mental Capacity Act 2007 (MCA). At the time of our inspection, 100% of staff had received this training. Staff understood their responsibilities in relation to consent and decision making according to legislation, including the MCA (2007).
- Crews assessed a patient's ability to weigh up, understand and retain information to aid decision making in relation to mental capacity. The consent policy was in date and provided guidance relating to consent in children and young people the 'Gillick Competence'. The Gillick competence aids decision making in a child under 16 years of age and to enable them to consent to medical treatment, without the need for parental permission or knowledge. The policy referred to the Mental Capacity Act (MCA, 2007) and Deprivation of Liberty safeguards (DoLs 2009).
- Clinical crews routinely sought verbal consent prior to treatment. Crews made best interests decisions for patients that were unable to consent due to injury or unconsciousness for example.
- Patient report forms had a specific section to record if a patient had provided consent, implied consent or was unable to consent due to illness or injury. We reviewed ten PRFs, which all indicated the level of patient consent.

Are emergency and urgent care services caring?

Compassionate care

Emergency and urgent care services

- Staff treated patients with dignity and respect in often very challenging, public environments. During our inspection, we saw that vehicular positioning and the use of blankets assisted in protecting the privacy of a patient from the public eye.
- We did not have the opportunity to observe relatives travelling with patients during our inspection. Staff described that they always tried to facilitate taking a relative during transfer but this depended on space within the aircraft. The pilot was accountable and made the final decision.
- Staff provided information cards to specify which receiving hospital they were transporting the patient. This ensured people were informed of the patient's destination in the event of them being unable to accompany their relative.
- Staff offered pain relief in a timely manner, once thorough initial patient assessments had taken place.
- Clinicians spoke to patients in a kind and reassuring manner. During an inspection, we saw staff providing support to a patient with serious injuries.
- We reviewed patient feedback during our inspection. One patient said: "the paramedic talked to me and held my hand the whole way to hospital. The air crew did an amazing job, I feel very lucky they were there to help".
- Patient feedback was very positive. Comments included: "my relative is continuing to recover; this I am sure is due to your wonderful service". Another patient said, "They were all so kind, considerate and professional in every aspect".
- The service kept a 'smile file', which held letters and thank you cards from patients and relatives of patients who had received care and treatment. All correspondence showed that staff had demonstrated kindness and compassion.
- Staff received mandatory training in privacy and dignity. At the time of our inspection, 100% of staff had completed this training.
- The service was in the process of conducting a patient survey. Initial findings (based on a sample of 21 patients) were that 100% of responses were 'extremely likely' to recommend Essex and Herts Air Ambulance to friends and family if they needed care or treatment. Of

those who felt able to respond (those who were conscious or from information provided by relatives), 100% said they would rate the overall care they received from the air ambulance crew as excellent, rated the comfort of the helicopter as excellent and rated overall satisfaction with the ambulance crew as excellent.

Understanding and involvement of patients and those close to them

- Staff explained treatment and procedures in a way that patients could understand. Necessary treatment was described in plain English so patients knew what to expect.
- The service recognised that illness and injury affected not only the patient, but family members, and loved ones also. They had identified that during times of critical illness or injury, there was not always time to explain treatments provided or, in the case of death, families were often left with many unanswered questions about the care and treatment a loved one had received.
- In response to this, the service had implemented the role of patient liaison manager (PLM) to support the welfare needs of patients. This role facilitated the explanation of previous episodes of care and treatment to relatives. This also enabled staff to signpost patients and relatives to other organisations who provide specialist support in the recovery phase of illness or injury.
- We reviewed examples of cases that had previously used the PLM role. Information gathered during conversations demonstrated patients understood the care and treatment they had received, but also showed the service used feedback to improve or adapt future care provision.

Emotional support

- Patient feedback overwhelmingly demonstrated that crews had acted in a kind and supportive manner whilst providing care and treatment.
- Staff routinely supported family and loved ones at the scene of critical illness or injury. Staff described how important it was to keep family members informed of treatment and transport plans.

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- The air ambulance does not transport deceased patients. In the event of patient death, clinicians worked with other emergency services at the scene to provide support to relatives, loved ones and bystanders in the event of experiencing traumatic events.
- Staff described awareness of relatives' emotional needs. For example, after illness or injury, the patient liaison manager role enabled staff to signpost relatives and loved ones to other organisations for assistance.
- The airbase chaplain and deputy chaplain were easily accessible to staff and offered emotional support. Senior managers recognised staff's regular exposure to traumatic events whilst providing care and described an 'open door' policy to all staff to offer support.
- Staff described how regular contact with patients who had previously been treated by clinicians or lost loved ones through illness or injury provided emotional support and gave patients and relatives the opportunity to ask questions. This provided staff with the opportunity to support patients and relatives after traumatic events.
- The service had implemented an award in memory of a previous patient. The 'student clinician of the year award', was awarded to a member of staff who had exhibited the same values as the patient, who sadly died. Staff described how this helped the family to remember their son.
- The service planned and delivered care in collaboration with the local NHS ambulance Trust. Mission details came from a dedicated critical care desk at the local emergency operations centre.
- Advanced planning meant the service met the needs of local people. Between 7am and 9pm in daylight, the air ambulance was available. During times of diminished light, crews used a rapid response vehicle for emergency calls.
- Services were planned and delivered in collaboration with the local NHS ambulance trust. At the time of our inspection, the service was in the process of planning to provide a 24-hour service and was actively seeking clinicians to fulfil this ambition.
- Monitoring of data had shown an increase of calls between the hours of 6pm and 2am. In response to this, the service had implemented an additional rapid response vehicle during these hours on Friday and Saturday evenings. This provided support not only to the local NHS ambulance trust but also gave the public additional access to advanced clinical support.
- Bi-monthly air operations meetings allowed staff to maintain regular communication with the local NHS ambulance trust to plan services to meet the needs of the public.
- The design of the base location and facilities met the needs of service planning and delivery.

Supporting people to manage their own health

- Due to the nature of care provided, the majority of patients were critically ill or injured. Post treatment, the team of patient liaison managers signposted patients and relatives to specialist services to enable them to manage their own health, learn more about their condition, and seek additional support if required.

Are emergency and urgent care services responsive to people's needs?

Service planning and delivery to meet the needs of local people

Meeting people's individual needs

- The service had access to a translation telephone line to aid communication with patients whose first language was not English. Staff also described using relatives for communication support where appropriate.
- Staff described various forms of verbal and non-verbal techniques to communicate with patients and explained how family and friends assisted in this process, where appropriate.
- Training records demonstrated that 100% of clinical staff had received training in dementia awareness and learning disabilities awareness.
- The service did not transport patients under section 136 of the mental health act unless there was an underlying medical need such as major trauma or illness. At the time of our inspection, 100% of had completed training

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in conflict resolution. Patients with mental health illness were assessed on an individual basis to allow crews to make informed decisions on the most appropriate method of treatment and transport.

- Due to the nature of emergency care, staff did not routinely have access to special notes or specific information about a patient and the critical care desk did not always have access to this information. Thorough patient assessment and history taking enabled staff to tailor treatment and care that was appropriate on a case-by-case basis.
- The service could request assistance from the local NHS ambulance trust in the event of conveyance of a bariatric patient. Due to the complex nature of flying, weight restrictions and limited space, air transportation was not always possible. Dynamic risk assessments carried out by staff ensured the safety and welfare of crew and patient at all times.

Access and flow

- Requests for air ambulance support came direct from the local NHS ambulance service trust. The local trust provided a dedicated critical care paramedic and control room dispatcher on the critical care desk to effectively triage calls, in a timely manner to ensure appropriate tasking.
- Information technology systems allowed staff on the critical care desk to see the availability of crews, including crew names and call sign information.
- The service monitored response times from receipt of call to launch time through the electronic database in use. The target time for this was below five minutes. From 1 January 2017 to 10 January 2018, the service mobilised within five minutes in 100% of cases.
- Additional key performance indicators showed data on operational statistics such as the number of missions per month, aircraft availability and serious incidents.
- The airbase was located near to major road networks to allow timely dispatch to incidents by rapid response vehicles.

Learning from complaints and concerns

- From February 2017 to January 2018, the service had received no complaints.

- The service had effective processes in place to investigate and learn from complaints. Staff had access to a standard operating procedure for complaints. We reviewed this document and found it contained guidance for all staff of the actions to take in the event of a complaint receipt.
- Complaints were a standard agenda item at governance meetings. The registered manager described that learning from complaints, was shared at team meetings and governance meetings.
- Key performance indicator (KPI) data reflected complaint volume. This allowed the service to monitor and track potential rises in complaints and identify any potential themes or trends.
- All complaints were logged on to an electronic safety management system to ensure that complaints were identified and dealt with in a timely manner.
- The service's website provided contact information for patients and the public on how to make compliments, comments or complaints about the service received.
- Staff provided patients and relatives with information cards and the offer of post-incident support. The card signposted staff on how to feedback any comments relating to care provided.
- The service worked in conjunction with the local NHS ambulance service trust to ensure sharing of complaint information from the relevant patient advice and liaison service with joint investigations taking place, where appropriate.
- The service had a named point of contact at the local NHS ambulance trust for joint investigation of incidents. Bi-monthly operations meetings took place with the local NHS ambulance trust to raise concerns, discuss complaints and review incidents and subsequent learning.

Are emergency and urgent care services well-led?

Leadership of service

- The service had a clear leadership structure in place. A chief executive officer, who was accountable to a board of trustees, led the service. The rest of the executive

Emergency and urgent care services

board consisted of an experienced range of clinical and non-clinical staff in roles including, but not limited to; clinical director, medical director, clinical managers, clinical operations manager and a clinical governance and training lead.

- Leaders were experienced, knowledgeable and demonstrated passion whilst performing their roles. We saw evidence that the executive board was highly visible to not only internal staff but also to staff from other organisations and members of the public.
- The service enabled staff to perform dual roles in both clinical and leadership positions. During our inspection, senior staff demonstrated enthusiasm to develop existing staff in to more senior roles and recognised key skills and strengths that staff possessed.
- Staff unanimously told us that the senior management team were visible, approachable and well respected. During our inspection, we saw that members of the executive board engaged with staff on a regular basis.

Vision and strategy for this this core service

- The service's vision was to 'provide the highest quality pre-hospital life-saving service 24/7 in Essex and Hertfordshire.
- The service's values underpinned the vision, these were; 'Innovative in driving forward best clinical practice, Dedicated because we care about the cause, our patients and each other, Trustworthy in working openly and honestly, Passionate about going the extra mile and Professional in treating everyone as they would wish to be treated'. Staff could describe the values and demonstrated their passion in the course of their work.
- The service had a comprehensive strategy for 2017 – 2022. The strategy clearly defined clinical, operational, financial and partnership objectives. Objectives had clear timelines for achievement and mirrored our discussions with senior members of the team during the inspection process.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was an effective governance framework in place. A variety of meetings took place with representation from all staff.

- Senior management team meetings monitored progress on the service's operational strategy. Clinical and operational managers were located at the base location to feed information to the senior team in a timely manner.
- Death and disability (D and D) meetings took place on a weekly basis. This gave staff of all clinical grades the opportunity to carry out case reviews of missions attended in the previous week. A senior consultant in emergency medicine chaired meetings and pre-hospital care, along a broad range of clinicians including the clinical director, critical care paramedics, doctors and pilots. Serious incidents and learning from D and D meetings were discussed at executive team meetings.
- During our inspection, we observed a meeting taking place. In depth discussion around a particular case, including all aspects of clinical care, scene management, pilot and flight crew input took place. Discussion was open, with actions allocated to designated staff members to either improve or adapt future practices.
- We reviewed register attendances for both the D and D meetings and clinical governance days (CGDs). Registers showed a good attendance at meetings with a broad range of clinical staff representation. Senior staff supported staff to attend D & D meetings and monitored attendance to meetings. Recent change meant staff could now attend one meeting a month, on a rest day and receive pay to reflect attendance and participation.
- Monthly CGDs gave staff from both the service and external medical services access to these events. CGDs allowed staff to reflect on previous cases and share knowledge and training around specific events including, but not limited to; burns, blunt and penetrating chest injuries and the unwell child. A broad range of staff attended CGDs.
- The service had an overarching risk register for both registered locations. The risk register was in the process of migration to a newer, more comprehensive version at the time of our inspection, and was waiting sign off by the board. The risk register demonstrated appropriate identification and recording of risk. All risks had clear ownership, regular reviews and documentation of actions taken to mitigate known risks.

Emergency and urgent care services

- The senior executive team met on a monthly basis. We reviewed meetings minutes from December 2017, which demonstrated a broad attendance of staff from the senior team.
- The senior management team regularly oversaw key performance indicator (KPI) data. KPIs measurement was through information technology systems and reflected various indicators, including but not limited to; shifts covered, clinical complaints, number of complaints that invoked the duty of candour and the number of missions per month.

Culture within the service

- Staff demonstrated passion and drive to provide the best possible care. The culture within the service was overwhelmingly positive. Openness and transparency was encouraged at regular debrief meetings, clinical governance meetings and senior staff maintained an 'open-door' approach to encourage staff to speak up if needed.
- Staff described the senior management as 'supportive, approachable and like family'. Staff feedback showed that senior leaders were visible and regularly checked staffs' welfare.
- The senior management team also described the service and its staff as a 'family', a description that was echoed by all other staff.
- The organisation offered wellbeing support to staff and had a chaplain who regularly visited the airbase. The service worked with two other air ambulances to establish a charter (The McQueen Charter) to support positive mental health and well-being for staff.
- The service recognised that repeated exposure to traumatic events could affect a crewmember's mental health. Staff had access to a variety of support mechanisms to understand positive health and well-being.
- The service provided temporary beds to ensure staff were well rested prior to traveling home at the end of late finishes on shift.
- Regular debriefing provided staff with an opportunity to talk about previous traumatic experiences in a forum that was safe and supportive.

Public and staff engagement (local and service level if this is the main core service)

- The service actively sought engagement opportunities with the public. Staff encouraged local groups to attend tours of the airbase to learn more about the service they provided. We reviewed positive feedback from local groups who expressed thanks to the service for providing the opportunity to learn more about the service's role in the community. A wide range of people could attend, including school groups and families. The fundraising team facilitated tour bookings and visits.
- The service's website contained a vast range of information for the public, who could explore recent mission updates (anonymised), data about the service and real life stories. Quarterly 'Flight for Life' magazines kept the public updated about service developments, charity and fundraising matters and real life stories of patient care.
- Patient feedback was encouraged through the service's website or through feedback cards, left with either the patient or relatives, providing contact details of the patient liaison managers.
- Staff maintained regular contact using social media to promote clinical governance days and other various learning opportunities.
- As the service was charity based, it invested time engaging with a team of approximately 300 volunteer workers. Senior management told us that the service was only possible due to the team of dedicated volunteers who gave so much time to support the charity.
- In June 2017, the service celebrated 20 years of the air ambulance and gave the public the opportunity to attend a 'celebration event and family fun day'. This coincided with the launch of the brand new air ambulance, used at the north Weald air base. The tour used free flying hours, from the specialist aviation service that provided pilots to the service. This enabled 20 local flights to allow members of the public time to meet crews and clinicians and view the new helicopter. No clinical missions were compromised at this time. The helicopter could not be used operationally until completion of conversion and additional training.

Emergency and urgent care services

Innovation, improvement and sustainability (local and service level if this is the main core service)

- Senior staff recognised doctor recruitment as a key challenge for the service. In the aim to launch 24-hour air ambulance and RRV cover in the future, senior management had implemented a recruitment programme in collaboration with a local NHS Trust to ensure that the service was sustainable with enough staff.
- The service was working towards accreditation with the Intercollegiate Board for Training in Pre-Hospital Emergency Medicine (PHEM). PHEM is a new sub speciality of medical practice, which focuses on the provision of on-scene and in-transit critical care. The service recognised that this would encourage further recruitment of doctors to sustain and improve the service provided.
- The recently introduced patient liaison managers (PLMs) demonstrated that the service had adapted and overcome the challenge of getting feedback from patients and relatives. This new way of seeking feedback provided support to patients and relatives after often, very traumatic events. This role also enabled the sharing of outcomes and learning with other organisations with the focus of improving care delivery.
- The service's staff had won two awards at the 2017 Air Ambulance Awards of Excellence. One member of staff received the title of 'Paramedic of the year' and another member was for 'Innovation of the Year' at the mind matters conference.
- The service had introduced a new Post-Doctoral Research Fellow post role in collaboration with a local university. Going forward, the post would realise the ambition of defined research pathways to provide evidence based care.
- The service ran a student elective programme to provide medical students with the opportunity to learn about emergency pre-hospital care and air ambulance provision.
- The service demonstrated its passion in providing timely care and good outcomes from out of hospital cardiac arrests. It placed emphasis on the importance of early cardiopulmonary resuscitation (CPR) and defibrillation. A team of ambassadors had commenced a school CPR programme to teach children the basics of resuscitation.

Outstanding practice and areas for improvement

Outstanding practice

- Staff from all clinical and non-clinical grades demonstrated overwhelming passion, commitment and drive to deliver the best care possible.
- The service placed emphasis on the mental well-being of staff through the provision of a “mind matters” conference, focusing on mental health, stress and post-traumatic stress disorder in the pre-hospital environment. Staff were supported to look after mental wellbeing and the service offered a range of counselling and trauma risk management to provide psychological support systems for staff to allow the service to proactively support staff in the wake of traumatic events.
- The service was passionate about engagement with the public. Recent projects included the rollout of training in cardio-pulmonary resuscitation (CPR) to young people within the area it served. Airbase tours, offered to members of the public, provided valuable engagement opportunities to a wide range of people to learn about the service provided.
- Staff showed passion for providing support to patients and relatives/loved ones after initial injury or illness. The patient liaison manager roles effectively communicated and enabled patients to gain important information about the treatment they had received.
- The service actively encouraged and promoted clinical governance days and learning opportunities to internal and external staff from the wider community.
- The service was providing medical students with opportunities to gain experience through a placement scheme.
- Staff had access to a wide range of training equipment with weekly practice scenarios taking place to embed learning. Simulation exercises took place on a regular basis, involving a wide range of staff.