LAP assessment report

Helimed house

LAP Assessment Report ID : LAP-02399

Inspection visit date(s): 10 March 2026

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Helimed house
Location findings

Ratings for this location

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

Overall location summary

Helimed House is based in Norwich and provides urgent and emergency care for people across the Norfolk and Suffolk counties, operated by East Anglian Air Ambulance (EAAA) Service. It operates an air ambulance to provide critical and urgent care to people involved in serious incidents or in places hard to reach by road. The service also has 2 emergency road vehicles (critical care cars) that enables the service to reach people when the air ambulance is unable to fly or in areas where it is inaccessible for the air ambulance to land safely. The core team includes 2 air ambulance pilots, a helicopter emergency medical service (HEMS) trained doctor and critical care paramedic. The service operates 24 hours a day, 365 days a year. It is tasked to attend incidents by the local NHS ambulance service and is funded by charitable donations.

The service operates throughout the whole year with the air ambulance being able to fly day and night. EAAA is the only HEMS service to operate its air ambulance service through the hours of darkness in the East Anglian region. Air ambulance staff are trained to use night-vision goggles to fly in the hours of darkness. Where staffing or weather conditions prevented flying, the Norfolk and Suffolk counties were

covered by the Cambridge air ambulance team.

In 2025, EAA completed a total of 2,738 missions , 1,573 were air ambulance; of which 903 were at night. Most patients were treated within the Norfolk County and the service completed an average of 7 missions a day in 2025.

This Air Ambulance service provided the following regulated activities: diagnostic and screening procedures, surgical procedures, transport services, triage and medical advice provided remotely and treatment of disease, disorder or injury. The service had a service level agreement to provide critical and urgent care for the local NHS ambulance service.

We carried out a short notice comprehensive assessment on 10 March 2026 due to an aged rating and CQC assessment priorities. This is the first time the service has been inspected against the new CQC single assessment framework and methodology. At the last assessment we rated the service as outstanding across all key questions. Following this assessment the rating remained outstanding overall.

Safe

Rating Good

Our overall rating of safe at Helimed House has changed to good.

We looked at 8 quality statements under the new single assessment framework and methodology.

The service had an open learning and incident reporting culture, with both staff and patients feeling able to raise concerns, patient safety was at the centre of providing harm free care. Managers investigated incidents thoroughly, shared learning and were transparent to improve service and promote high quality care. The service had comprehensive systems to protect patients and keep them safe. The team were engaged in reviewing and improving safety systems and understood and implemented patient safeguarding arrangements. There were enough staff with the right skills, competencies qualifications and experience in the service to ensure high quality care. The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care. Managers made sure staff received training and had regular appraisals to maintain high-quality care. Staff managed medical gases and medicines safely. Staff identified and reacted to unexpected deterioration in a patient's condition and used innovative treatment to ensure optimal outcomes. Staff understood and managed risks from the environment. The vehicles and

equipment met the needs of patients, were visibly clean and well-maintained. The service used effective governance systems to manage risks and patients benefited from a culture of safety and high-quality patient focused care. Leaders encouraged innovation and research to achieve sustained improvements in safety and continual reduction in harm.

Effective

Rating Outstanding

Our overall rating of effective at Helimed House has remained outstanding.

We looked at 6 quality statements under the new single assessment framework and methodology.

Staff not only met good practice standards in relation to national guidance, but they also contributed to research and development of national guidance to improve patient safety and outcomes. Patients, and where appropriate those close to them, were involved in assessments of their needs. Staff considered patient's physical emotional, communication and personal care needs. Care was based on latest evidence and good practice guidance. Patient outcomes met expectations, and harm free care was the norm. Patient's pain was quickly identified and well managed.

Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. Where relevant, volunteers are proactively recruited and supported in their role.
Staff made sure patients understood their care and treatment to enable them to give informed consent. The service regularly updates its policies and processes for using volunteers and innovative practice, and the use of volunteers helps to measurably improve outcomes for people.

Caring

Rating Outstanding

Our overall rating of caring at Helimed House has remained outstanding.

We looked at 5 quality statements under the new single assessment framework and methodology.

Patients were treated with kindness and compassion. Staff were motivated and inspired to offer care that is kind and promoted people's dignity. Relationships between people who use the service, those

close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders, the service's Aftercare team and volunteers. Staff protected patient privacy and dignity consistently and this was embedded in everything that staff did. They treated patients as individuals and supported their preferences, people felt really cared for and that they mattered. Staff responded to patients in a timely way. Patients had the opportunity to ask questions and were responded to in an open and caring manner.

Responsive

Rating Outstanding

Our overall rating of responsive at Helimed House has remained outstanding.

We looked at 7 quality statements under the new single assessment framework and methodology.

Patients, or their representatives, were involved in decisions to express their preferences and ensure that their individual needs were met. The service provided information which patients could understand. Patients were invited to give feedback, knew who to speak with if they had concerns and were confident the service took their concerns seriously. The service has a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. The service monitored and worked to improve access. Vehicles and equipment were adjusted to meet the needs of people with conditions which could create a barrier to access. Staff used technology innovatively to ensure people had timely access to treatment, support and care. The service demonstrated where improvements had been made because of learning from reviews and that learning was shared with other services. The service worked to reduce health and care inequalities through service planning, quality monitoring, staff training and feedback. The service supported staff wellbeing.

Well-led

Rating Outstanding

Our overall rating of well-led at Helimed House has remained outstanding.

We looked at 7 quality statements under the new single assessment framework and methodology.

Leaders and staff knew the service's local vision, aims and objectives and understood how their service

aligned with this. The leadership, governance and culture drove and improved the delivery of high-quality person-centred care. There was a culture based on speaking up, listening, learning and trust. Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. They were visible, knowledgeable and supportive, helping staff develop in their roles. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the services strategy and plans. Staff felt supported to give feedback and were treated equally, free from bullying or harassment. Staff understood their roles and responsibilities. Leaders had sound oversight of the quality of service being delivered through effective governance and risk management systems. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Staff with protected characteristics felt supported. There was a culture of continuous improvement with staff able to contribute ideas through a quality improvement programme.

Emergency and urgent care

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

Our view of the service

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People's experience of the service

We spoke to 3 patients and family members who had used the service and reviewed patient survey results and stakeholder feedback given to the service. Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people. Patients were positive about the staff treating them with warmth and kindness and providing effective care and support. Patients told us that the care and support offered by the Aftercare Team was well balanced and timely in helping them understand and manage the trauma they had been through. A patient reported they were reassured by staff and meeting the team enabled them to understand the care and treatment received when they could not recall this. Support was extended to patient’s families which allowed them to ask questions and feel included in coming to terms with the event. Both financial and emotional support was offered until the individual felt ready to be discharged by the Aftercare team, this meant that there was ample opportunity to ask questions that was individualised.

Safe

Rating Good

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. Leaders had systems for identifying and responding to safety risks. The service had safety processes for the preparation of vehicles, equipment and for the patient journey between locations. Medicines were managed safely. Patients were safe from neglect, abuse and discrimination. Patient's gave informed consent where possible prior to any physical support required of staff. Where they were unable to consent due to the nature of the event, those close to them were involved in decisions which were made in their best interests.

At our last assessment we rated this key question outstanding. At this assessment the rating has changed to good. Patients were safe and protected from avoidable harm.

Learning culture

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service had a strong proactive and positive culture of safety, based on openness and complete honesty. Staff and leaders actively listened to concerns about safety and thoroughly investigated and reported safety events. Lessons were learnt to continually identify and embed good practice. Learning was shared widely across the service and more widely with the other provider locations, where appropriate.

Staff knew how to access an incident reporting policy, which outlined incident reporting procedures, levels and timescales of investigation. There was a risk assessment matrix applied to each incident, according to severity. Staff told us how they were encouraged to raised concerns and report incidents and near misses, which was in line with this policy.

Staff recognised and reported incidents using the internal incident reporting system, using handheld and office based electronic devices. Managers investigated incidents and shared lessons learned with the whole team and understood the value in sharing these with external and contracted partner organisations to prevent avoidable harm. We saw evidence of such wider learning shared with the service's contracted NHS ambulance services and acute trust.

The service medical director ensured staff's welfare, offered them downtime and psychological support.

The service managed patient safety incidents comprehensively. The service had approached incidents through a no blame culture, with a strong focus on improvement and innovation through lessons learnt. Staff were openly encouraged by leaders and each other to discuss safety and any learning. They proactively identified missions they had attended that offered rich opportunities for collective reflection, learning, and improvement, each one chosen for its potential to drive safer practice and reduce patient harm.

The service completed complex case reviews (CCR) for care episodes to offer clinicians time to reflect and review care given with the emphasis on learning. This process highlighted any areas of excellence, learning or improvement. The service had carried out 45 CCR between January 2026 to March 2026. The service commissioned After Action Reviews (AAR) from an independent consultant not involved in the care episode to allow for a 'deep dive' into cases. All AAR were completed with the ambulance crew, NHS ambulance and external stakeholders such as the police. This showed an exceptional practice as external stakeholders were involved to ensure the accuracy of review and timely shared learning with external partners. We reviewed 3 AAR during our onsite visit, they had a set structure including review of decision making, concerns identified and recommendations. For example, simulation training scenarios to be run joint with Helimed House and the NHS ambulance trust for split site stabbing/major incident to ensure processes and systems supported the most effective operational approach. This ensured that all services were improving safety not limited to Helimed House staff.

When things went wrong, staff apologised and gave patients honest information and suitable support. Ambulance crew had used a heat mat to warm a patient, which resulted in a burn on their abdomen. The service informed the family of this and an investigation into the use of the product was conducted to prevent future occurrence. Immediate action was taken by the service to remove the product until an investigation was conducted with the local NHS hospital to prevent future harm. Staff we spoke with were aware of the incident and the action taken by senior leaders to reduce the risk of any future patient harm.

There is a genuinely open culture in which all safety concerns raised by staff and people who use service was highly valued as being integral to learning and improvement. Data we reviewed showed incidents were comprehensively investigated, and timely, effective action taken to

reduce the risk of recurrence. We looked at the service electronic system for managing incidents were rated according to risk and leaders proactively reviewed these in line with policy recording action taken. Recent examples of incidents included staff reporting a needle stick injury, thermal burn and equipment failure.

Incidents were analysed by senior leaders to identify trends or themes and potential links to individual practitioners. Where additional staff training or support was required to ensure competence, this was provided.

Staff understood duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff received feedback from internal and external incident investigations, for example following a thermal burn to a patient there was a team read sent out to all clinical staff regarding the incident and change in procedure to prevent future occurrences. A team read is a structured communication document to aid communication with staff used within the service.

The service provided mandatory training in key skills to all staff. Managers monitored mandatory training and alerted staff when they needed to complete updates. The data showed all staff were compliant with their mandatory training. Non-compliance was only seen in those staff currently on long term sick, maternity or recently joined the service and were onboarding.

Clinical staff completed training on recognising and responding to patients for example, with learning disabilities and/or living with dementia. Staff also completed and refreshed all their care certificate training (CCT) standards every 3 years and were reminded before any expired.

The service had a systemic and embedded approach to its culture of learning. For example, at the end of each shift, the ambulance crew and pilots completed a standardised post mission debrief to discuss the overall quality and effectiveness of each mission. This enabled ambulance crew to identify immediate learning and improvement. External stakeholders told us that this process was effective in identifying learning at the earliest opportunity in a safe environment to prioritise safety and learning. An example was given where clinical resource management refresher training was introduced across all air ambulance services due to a recognition that ambulance crew did not follow safety protocol and released their seatbelts prior to secure landing. Helimed House ambulance crew acknowledged their actions and welcomed the new refresher training. This demonstrated the commitment to wider learning

across the network to drive improvement and safety.

We spoke with both clinical and non-clinical staff that told us they were supported and encouraged to their allocated training budget on continuing professional development courses to support their role. The continuing development of the staff's skills, competence and knowledge was recognised by leaders as being integral to ensuring high-quality care. For example, a non-clinical staff member told us that they received training to manage bereavement calls to ensure that they were effective in providing compassionate, patient, and practical support to individuals who have recently lost a loved one. They felt the training supported them in key aspects such as active listening, clear communication regarding next steps, and signposting to further support services.

Safe systems, pathways and transitions

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service worked with patients and healthcare partners to design, establish and maintain safe systems of care, where safety was well managed and monitored. Staff made sure there was always continuity of care, including when responsibility for patient care moved between different areas of a service and between providers. Staff were committed to working collaboratively and found innovative and efficient ways to deliver more joined-up care to people who use services.

Ambulance crew would risk assess the most suitable mode of transport for each mission based on factors such as accessibility and weather conditions. These decisions were made as a team in conjunction with the air ambulance pilots. Where weather conditions made flying unsafe this was communicated with the crew as well as the local NHS critical care control desk.

Ambulance crew had oversight of a digital dashboard with real time travel distance by air and road to aid rapid decision making and access to the closest major trauma centres and specialist units to transfer patients who needed critical care.

Safety and continuity of care was a priority throughout people's care pathway. Patients had continuous monitoring by ambulance crew. The on-call duty consultant supported the ambulance crew with rapid decision making in time critical situations and non-clinical tasks such as pre-alerting patient receiving hospitals to ensure seamless continuity of care for patients. This was described by seniors as a 'phone a friend' service. This collaborative approach meant that they were working as efficiently as possible to deliver timely care.

The management of safe systems and care was a priority for the service. The service had policies and standard operating procedure (SOP) to ensure that patient safety was maintained at the scene and beyond. These included night operations, rare procedures and analgesia and sedation SOP. There was a strong focus on all aspects of using various tools and audits to look for themes and trends for further investigation, change or improvement if needed. Oversight was managed through monthly clinical governance days were held with senior managers to consider risk and performance and health and safety committee meetings were held to consider all aspects of safety across the service.

Daily medical team safety briefing checklist was completed at the beginning of each shift. This included, but was not limited to, welfare checks and, review of all mandatory training for each ambulance crew member as well as tasks to complete during the shift.

Ambulance crew recorded pre-shift checks digitally, and staff were reminded of weekly and monthly checks such as equipment, vehicles and infection, prevention control and hygiene through the services digital management system. Ambulance crew were required to read the latest team reads (a structured communication record used to convey timely information and updates in practice). Crew were required to review their compliance against mandatory training at the beginning of every shift. This ensured that the ambulance crew had the skills, knowledge and competence to perform safely and effectively on every shift.

When overall responsibility for the care and treatment of a patient moved to a different service provider, such as transfer to the NHS, there was effective communication, which allowed for seamless transfer. Key performance indicators were continuously reviewed to ensure that the service was effective in its delivery of pre-hospital emergency care. For example, first time to arrival on scene, arrival to emergency anaesthesia and successfully placing a breathing tube on the first attempt. The continuous monitoring against set indicators as well as previous quarters allowed for senior leaders to address changes in compliance and review potential causes or

learning without delay.

Staff planned and organised care with people, together with partners and communities in ways which ensured continuity after transfer to the destination. Ambulance crew would leave contact details for the Aftercare team with the patient or family upon transfer to allow for ongoing support.

Safeguarding

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard and framework embedded to identify themes and trends. The service worked with patients and healthcare partners where required, to understand how best to keep people safe, what it meant for individuals and the best way to achieve that. Staff concentrated on protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. They understood their responsibilities for raising and sharing safeguarding concerns through the relevant safeguarding routes, including the NHS ambulance trust process and EAAA safeguarding leads. The service had well established partner working and contacts around safeguarding with their contractors and local authorities. Referrals made by staff were automatically sent to the 3 level 4 trained safeguarding leads within the service for follow up and establish outcome of the referral and share any learning with the staff teams.

The service had started receiving feedback from the NHS ambulance trust for safeguarding concerns they had raised. The safeguarding team also cross-referenced monthly safeguarding referrals against the provider database to ensure that records were accurate and that staff were referring in line with policy. This process had helped identify a few referrals that were assigned to another air ambulance provider and not Helimed House.

Staff received adult and children's safeguarding training. Data showed 95-100% compliance for frontline and ground staff. The service had an up to date safeguarding policy which reflected the national guidance for adults and children. Staff were trained in line with the national intercollegiate guidance ensuring all staff were trained appropriately to their role.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence of 3 safeguarding referrals made by ambulance crew in accordance with policy. Expert safeguarding advice was available to support staff from Monday to Friday, by the safeguarding team, who were trained to level 4 and 5. Out of hours the ambulance crew were able to discuss concerns with the on-call duty consultant.

Safeguarding concerns were considered at point of care for all missions. Senior leaders reported that they had seen a change in clinical staff documenting safeguarding considerations as a core intervention. Patient records had dedicated areas for staff to record safeguarding details and numbers. Ambulance crew would also document clear decisions when a referral had not been made but was considered.

The service did not complete any formal annual audits to ensure correct processes were followed and actions completed. However, there was robust oversight of clinical care within 24 hours of each mission where any potential missed safeguarding referrals would be captured. Further to this the service met with the NHS ambulance service monthly and feedback was received on the standard of referrals made by the service's ambulance crew. A total of 96 safeguarding referrals were made in the last 12 months. The NHS ambulance service we spoke with told us that referrals made were appropriate and had no concerns with how they were handled. This demonstrated active case review, external partner feedback, referral reconciliation and continuous oversight.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to during our onsite visit could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010).
The service was considering ways to make safeguarding for non-clinical staff more relevant by introducing bitesize monthly safeguarding updates such as those from the National Society for the Prevention of Cruelty to Children (NSPCC).

Involving people to manage risks

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. The service worked with people to understand and manage risks by thinking holistically. Staff provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

The service used patient record forms (PRFs) which were initially completed with the information received by the NHS ambulance trust control desk. Upon arrival ambulance crew gained as much information as possible to understand the requirements of the patient. This was supported with the use of innovative equipment and patient monitoring devices.

The service worked with patients to understand and manage risks. Patients' needs were met in ways which were safe and supportive and enabled them to do the things that mattered to them. This included for example, transferring a child to a major trauma centre to keep them with their family following a road traffic collision, placing the patient at the centre of their plan of care.

Due to the nature of some of the missions, patients were not always involved in decisions about their care and treatment. Staff were encouraged to listen to patients and family to ensure they were given the best advice to manage risks they were facing. We saw evidence of staff carrying out holistic assessments to ensure that conveying patients to hospital was in their best interest and supported comfort, privacy and dignity.

We spoke with 2 patients and a family member during our assessment who told us they were given the opportunity to meet with the Aftercare team where they spoke about the care and treatment they had received. They reported that this was important to them and a source of comfort to help understand the life changing medical emergency they had experienced.

Staff told us that they used trauma teddies when treating children to assist with identifying areas of pain and the teddies were made by volunteers within the service.

Safe environments

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service was aware of all potential risks in the care environment and controlled them comprehensively. Leaders collaborated with staff and external stakeholders to make sure equipment, facilities and technology supported the delivery of safe high-quality care.

The design, maintenance and use of facilities, premises and equipment kept people safe. The service used surveillance cameras on entrances and swipe card access to areas such as medicine storage and medical equipment. During normal office hours volunteers and office teams manged reception to sign all guests or external contractors, trainers were signed into the service and given a health and safety briefing before entering the internal premises.

The service had 2 dedicated sleeping facilities for staff to rest following their shift if they were not able to travel home. These were secure, safe environments specially built to offer staff the ability to rest and recover following missions. Senior leaders actively encouraged the use of these facilities in recognition of the nature of the role of their ambulance crew.

Helimed House had a multi-function facility for ground staff to operate a 24-hour,7 day a week service as well as innovative training facilities, rest areas, gym and welfare facilities for patients and family members for follow up care.

The service had a dedicated immersive simulation training suite that could replicate environments and challenges that clinicians had experienced when attending patients. This included recreating weather conditions such as wind, cold and heat. With images and videos of people, interiors and landscapes projected onto the walls, the simulation suite could recreate a scenario to assist with learning to support clinicians' training to remain focused in what could be chaotic environments. These facilities were accessible to external stakeholders to share best practice and deliver the best possible care to patients.

The service had policies and procedures in place to maintain a safe environment and staff

conducted regular planned safety checks and audits for safety. The service's estates team ensured that servicing and fire risk assessments were in line with policy and aviation standards. All staff were aware of their responsibilities for ensuring the environment was safe for patients and staff.

The design of the environment was wheelchair accessible throughout. The Helimed House Hangar provided protection for the aircraft, rapid response vehicles, medical gases and equipment and an area for essential on-site maintenance. Building temperature levels were centrally controlled to ensure they remained within specified levels to ensure engineers and ambulance crew could safely equip or work on the air ambulance and vehicles. Staff stored vehicles in a safe area that was inaccessible to unauthorised persons. The critical care car area had charging facilities for the hybrid car and the medical equipment contained within the vehicle. An automatic eject feature disconnected the vehicle from its charging point when staff started it. This ensured a fast and safe exit for the ambulance crew when they were tasked by road to a medical emergency, making it a more effective way to launch the critical car and get to patients more quickly.

The air ambulance and 2 critical care cars were all fit for purpose to meet the needs of the service and equipped to deliver rapid, critical care at the scene of serious incidents or medical emergencies. Ambulance crew would check the site for waste and products prior to leaving the scene. Leaders ensured staff were trained to use equipment and to manage diverse types of waste safely.

The ambulance crew on shift conducted daily safety checks on specialist equipment and recorded this digitally. We reviewed the vehicle check audits carried out by staff over a 2-week period and we found that staff completed these fully. The service had a system for staff to report faulty equipment and vehicles to the estates team who maintained a comprehensive record of action taken to address any faults.

Leaders maintained oversight of equipment to ensure it was safe and ready to use through the operational management digital system. Staff told us they had enough equipment to conduct their work safely and to support the treatment and care needs of patients. We saw evidence of action taken by senior leaders to prevent expensive equipment being damaged and ensure costly medical equipment was fit for purpose and ready to use during an emergency.

The service ensured up to date and serviced fire safety equipment was available on all vehicles and in the premises. Fire exits were clear and free from obstruction in office areas. The service stored Oxygen cylinders correctly, upright and in cages with no flammable or electrical equipment nearby.

Staff disposed of clinical waste safely, both inside vehicles and outside the storage areas. Staff segregated and labelled waste in accordance with the local policy.

Staff stored hazardous substances safely and information about the safe handling of products was available to staff.

Safe and effective staffing

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service made sure there were enough qualified, skilled and experienced staff, who received effective support, supervision and development. They worked together well to provide safe care that met people's individual needs.

The service employed its own clinical staff with critical care paramedics contracted through the local NHS ambulance trust. The deanery placed some pre-hospital emergency medicine (PHEM) doctors with the service as part of their PHEM training. All staff received a comprehensive service induction essential for their role. At the time of assessment, the service had 14 consultant doctors, 4 clinical fellows, 3 PHEM trainees and 3 critical care paramedics. They had a pool of 10 emeritus doctors contracted at NHS hospitals and worked as bank for Helimed House.

Core ambulance staffing consisted of a medical doctor and a critical care paramedic, day, and night. However, senior leaders told us that 40% of shifts had an additional staff member under supervision as part of their training. The service ensured ambulance crew took a rest break of 11 hours between shifts to ensure adequate rest.

The ambulance staffing rota for February 2026 showed all shifts were filled, with 3 occasions where a member of staff dropped a shift due to sickness at night. On these occasions the Cambridge base location covered the Norwich region.

Managers supported staff to develop through constructive, recorded, annual appraisals and constructive clinical supervision of their work. The service achieved 100% compliance with appraisal rates in 2025.

In August 2025, the clinical senior leaders implemented formal supervision monitoring of their senior clinical fellows and PHEM trainee doctors. Formal monitoring of supervision for all clinical staff commenced in January 2026. This was achieved through the new paramedic-led supervision model for seconded paramedic from the NHS ambulance trust. The development aimed to create a consistent, supervision model that supported a mixed-skill workforce and strengthened parity and capability across professional groups. Due to this being a new initiative the impact of this model was yet to be measured by the service.

Senior leaders were in the process of updating their current supervision policy to reflect the level of supervision needed for paramedics against a target so that they could measure compliance. This was yet to be formalised. Therefore, there was insufficient data to assess whether the service was supervising staff in line with their policy, but data suggested that supervision rates would be in line with target within the next 12 months.

The service had an overall vacancy rate of 3.1% for both clinical and non-clinical staff and low turnover rates. In the last 12 months 2 members of non-clinical staff had left the service to pursue other development roles. The service had low sickness rates of 1.4% in the last 12 months. Staffing records we reviewed showed a robust system in place for ensuring staff had the training, skills, and competencies needed for their role. New staff completed a corporate induction and essential mandatory training. An induction checklist outlined tasks and times for completion. 100% of staff that the service recruited within the last 12 months had completed an induction.

Staff we spoke with said they felt the service was safe. Ambulance crew had access to rest pods for shift crews at night and sleeping facilities if they felt fatigued following a shift and needed to rest. Staff were able to book a room in advance or at the end of their shift if required.

The service supported the learning and development needs of staff and made sure staff received any specialist training for their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they could practice skills in the training suite whilst on shift to consolidate or refresh skills.

Managers made sure all staff attended team meetings or had access to the information shared when they could not attend. We saw notes from team meetings and other general information such as team reads.

The service had 2 air ambulance pilots per shift who were under a subcontract with a specialist aviation service. The CRM process carried out by both the pilots and Helimed House ambulance crew ensured that everyone was empowered to raise any concerns to ensure safety whilst on a mission.

Infection prevention and control

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. The service assessed and managed the risk of infection. Staff detected and controlled the risk of infection spreading by following policies. Infection prevention and control data was collected and reviewed. Where required, actions were taken to improve shortcomings.

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

There was access to a local infection, prevention and control (IPC) policy and supporting guidance was accessible to staff. Staff received training on IPC.

Monthly audits were undertaken to ensure IPC compliance across operational bases, aircraft and RRVs. The service performed well in local IPC audits that we reviewed. In the most recent

audits, the scores showed compliance with infection prevention and control measures in all clinical areas. We saw evidence of environmental IPC checks such as legionella and air quality testing.

There was guidance to support staff to respond to infection prevention and control risks such as transmittable infections. We saw clinical staff were following infection control principles such as no jewellery and nail varnish. We saw an IPC notice board with signage prompting all staff to remain compliant with handwashing and the use of personal protective equipment (PPE) as outlined in the services PPE standard operating procedure. Staff had access to handwashing facilities, PPE, sanitisers and antibacterial wipes.

During our onsite visit all areas were visibly clean and had suitable furnishings which were clean and well-maintained. We checked 2 critical care cars and the air ambulance whilst onsite, all of which were visibly clean. Records showed that they had been cleaned in line with the service's IPC policy. Cleaning logs were centralised, and reports were reviewed by managers and the clinical governance committee to ensure compliance with the required standards.

The service followed the NHS Colour coding system to prevent cross-contamination and infection by designating specific cleaning materials (mops, cloths, buckets) to areas, ensuring high hygiene standards. This standardised approach reduced healthcare-associated infections (HAIs) by separating equipment used in high-risk areas (like toilets) from lower-risk areas (like offices).

Assurance of environmental cleanliness was achieved through a comprehensive control and audit framework consisting of local deep clean processes, audit, training and oversight from governance meetings. There was a weekly deep clean programme for the critical care cars and air ambulance which was logged digitally and reviewed by managers to ensure compliance with local policy. Routine microbial swabbing was not part of the local assurance process. However, leaders confirmed that surface sampling was undertaken where clinically indicated, such as during outbreak or incident investigation, in line with UKHSA guidance.

Staff understood the process for managing spillage of body fluids.

Staff supported infection prevention and control measures by following the uniform policy. The service had a dedicated sluice area with a decontamination shower and washing machine to remove contaminated uniform.

Medicines optimisation

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. The service used robust systems and processes to safely prescribe, administer, record and store medicines. The service took a proactive approach to improving the safe and effective use of medicines. The service drove improvements in practice locally and nationally in pre-hospital care. It conducted research in critical care treatments and their outcomes to drive innovation and improvement in patient care.

Staff followed systems and processes to safely prescribe, administer and record medicines use.

Staff stored medicines securely in controlled areas with restricted access. There were clear audit trails and robust oversight of controlled drugs (CDs - medicines legally subject to stronger regulation because of their potential for harm). Medicines were kept in sealed and traceable bags which were routinely checked, restocked and version controlled so ambulance crews always left base with complete, ready to use equipment. Staff used temperature monitoring systems in the stores to ensure medicines were kept within safe ranges, and they acted on any issues promptly. Staff also took steps to manage the extra risks of storing medicines on aircraft, including moving bags indoors during hotter periods and using validated insulated containers for blood products transported on missions.

Staff documented medicines administration on their electronic patient record system, which included details such as the dose, time and patient response. This supported accurate handover to other ambulance service and hospital teams. A paper handover form was also used during missions to ensure essential medicines information was shared immediately. All mission records were reviewed by a consultant within 24 hours, which helped ensure accuracy, identify learning and strengthen safe practice in relation to the use of medicines.

The service embraced human factors design principles, meaning equipment was organised in ways that made it easier for staff to work safely in challenging environments. Medicines bags were laid out consistently and only single strengths of certain medicines were carried to reduce

the risk of error. High risk medicines such as ketamine (a sedative) and rocuronium (a short-term muscle relaxant) were stored in clearly distinguishable packaging to prevent errors, and staff acted quickly when they identified a near miss relating to antibiotics that may look similar. This meant staff could easily identify and administer the correct medicines in low light or high pressure situations improving outcomes for patients.

There was a strong culture of reporting and learning from medicine incidents. Staff used digital systems to log near misses, equipment concerns and safety issues, with clear evidence that these were investigated, shared and acted upon. Monthly governance days, operational briefings and consultant reviews helped staff discuss complex cases, reflect on practice and make improvements. The organisation also demonstrated an active commitment to research and innovation, contributing to clinical studies and using data to improve patient care, including work on traumatic brain injury and alternative pain relief options.

Training and clinical support were embedded throughout the service. Staff had access to structured induction, simulation-based learning, on shift supervision and 24-hour consultant advice.

Overall, the service showed a proactive, forward-thinking approach to medicines safety. Systems were reliable, learning was embedded and the team demonstrated a strong commitment to delivering high quality critical care. This contributed to care that consistently aligned with best practice.

Effective

Rating Outstanding 

We looked for evidence that patients and communities had the best possible outcomes because their needs were assessed. We checked that patient's care, support and treatment reflected these needs and any protected equality characteristics, ensuring patient were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.
At our last assessment we rated this key question outstanding. At this assessment the rating has remained outstanding. This meant patient's outcomes were consistently good, and patient's feedback confirmed this

Assessing needs

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service made sure patient's care and treatment was effective by thoroughly assessing and reviewing their health, care, wellbeing and communication needs with them.

Clinical staff shared key information to keep patients safe when handing over their care to others. They knew what missions they were to undertake. Staff shift changes and handovers included all necessary key information to keep patients and ambulance crew safe.

Ambulance crew told us they monitored vital signs continuously so that they could quickly detect the deteriorating patient using equipment such as 12-lead electrocardiogram (ECG), invasive blood pressure monitoring and end-tidal carbon-monoxide, among others to monitor any changes in condition. These vital signs were uploaded to the electronic patient record and the duty on call consultant was also able to review these live remotely to offer support with rapid decision making to improve patient outcomes.

The service had a range of up-to-date policies and standard operating procedures to ensure ongoing assessment and treatment of patients such as National Early Warning scores and Sepsis. Staff knew how to access electronic versions of policies and procedures on their handheld digital device.

The service launched an innovative project to help determine if a patient had suffered from a bleed in the brain by taking a blood test. This enabled ambulance crew to make a faster diagnose and transfer patient to the most appropriate hospital for their ongoing treatment and care to improve patient outcomes.

We review patient care records which showed ambulance crew assessing, sedating and administering medicines in response to pain levels to make patients more comfortable.

Staff we spoke with told us they had access to various communication tools online such as

translation services to enable them to communicate with people effectively. The service used knitted teddies to aid effective communication with children during assessment to be able to deliver targeted treatment on scene.

Staff considered patient needs when planning transport activities. For example, ambulance crew had planned to transport a patient in the air ambulance, but due to change in the patient's condition crew made the decision upon re-assessment to convey by land as it would be safer.

Delivering evidence-based care and treatment

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service planned and delivered patient's care and treatment with them, including what was important and mattered to them. Staff did this in line with legislation. They worked to develop evidence-based good practice and standards.

Staff followed up-to-date policies to plan and deliver high quality care. All policies we looked at contained a creation and review date, and clear references to current national guidelines. Policies and processes took account of changes to professional guidelines and National Institute of Care and Excellence (NICE) guidelines.

The service was dedicated to working to improving patient outcomes by developing new treatments, equipment and skills through trials, extensive research, evaluation and by using the latest cutting-edge evidence in pre-hospital emergency medicine (PHEM). Areas of research at the time of our assessment included the Brain-First study to diagnose a bleed on the brain and performing resuscitative endovascular balloon occlusion of the aorta (REBOA) to manage cardiac arrest patients to improve outcome compared to traditional cardiac life support measures.

The service audited clinical processes carried out on missions to monitor performance. Service

data was monitored through a bespoke live dashboard for oversight. We reviewed the airways dashboard which showed ambulance crews compliance against the NICE guidance for Trauma Quality standard 1 which indicates people with major trauma who cannot maintain their airway and/or ventilation have drug-assisted rapid sequence induction (RSI) of anaesthesia and intubation within 45 minutes of the initial call to the emergency services. Data also reviewed intubation failure times for ambulance crew. In February 2026 there was 100% intubation achieved and there were no current themes identified.

Staff told us that they kept up to date with changes in practice and were encouraged to make suggestions if they felt current processes could be improved. These could then be assessed by the management team and if appropriate, changes would be made. Changes were communicated through team reads, meetings and governance groups. Ambulance crew said they were told about updates at the beginning of each shift to ensure they were aware of any changes in best practice guidance. Staff adherence to these changes were monitored through the review of missions by the senior leaders.

How staff, teams and services work together

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service worked well across teams and services to support patient. Staff shared thorough assessments of patient's needs when they moved between different services, so a patient only needed to tell their story once.

Staff and volunteers worked cohesively as a team to benefit patients. They supported each other to provide PHEM care, after care, use research to inform on practice to deliver a quality service and improve patient outcomes. The service had policies and practices to ensure good communication between other agencies. There was regular debrief meetings for managers and teams to review incidents and constructively challenge actions and decision making. The service also had effective service level agreements and memoranda of understanding with external agencies to ensure there was a clear plan of decision making and communications.

The service always worked well across teams and services to support people, which was vital to providing an effective service. The service attended regular meetings with other emergency response providers to discuss wider operation matters and response to emergency plans.

We reviewed patient care records and after-action reviews which detailed examples of how staff worked collaboratively across teams and services to improve outcomes for the patient and their families. For example, Helimed House staff supported with continuing treatment upon arrival at the local hospital urgent and emergency care department due to rapid deterioration on arrival.

The NHS ambulance trust reported that the staff worked closely in a professional and supportive manner. That this was strongly emphasised from induction and have had no concerns relating to staff crossing professional boundaries. They reported that Helimed House ambulance crew gained feedback from the paramedics to ensure that they are working collaboratively to ensure coordinated team-based care is delivered on every mission.

The service actively fostered integrated working by delivering joint training and co-designing pathways with system partners, ensuring consistently aligned practice and improved outcomes for patients. Staff told us that they liaised with local hospitals and trauma centres to enable the most efficient transfer of patients to the appropriate place. We saw evidence in after action reviews of pre-alert calls when leaving the scene and on landing at the hospital to ensure that receiving teams were prepared for handover. This meant that it avoided delay in handing over care and Helimed House ambulance crew were ready for re-deployment if needed. We spoke to external system partners who described the working relationship with Helimed House staff as “A true partnership”.

The Aftercare team offered specialist emotional and practical support to patients and their families following the aftermath of a medical emergency attended by the service. Patient and family feedback is highly supportive and described as “fantastic” and “comforting as I needed to know what had happened”.

Managers had fully considered staff welfare. For example, we saw evidence of a cold debrief carried out jointly with the NHS ambulance service following a baby death that ambulance crew had attended. Senior leaders acknowledge the impact missions had on staff and facilities were centred around supporting their physical and emotional well-being. For example, staff had access to an onsite gym, rest area, sleep area to stay after their shift if they were unable to

travel home.

Supporting people to live healthier lives

Score

4. Evidence shows an outstanding standard of care

Due to the context and nature of the service, there is no opportunity for staff to support patients to live healthier lives. The service focused on supporting people to live healthier lives supporting emotional and psychological health after their need for care. The evidence of reactive aftercare was of an exceptional standard.

The aftercare provided at Helimed House was for everyone not just their own staff. Debriefs were held with all external agencies that were involved in a mission such as police, fire and rescue and NHS ambulance services.
The Aftercare service was made up of specialist clinicians, providing vital emotional and practical support to those recovering from traumatic incidents and even members of the public who may have witnessed a traumatic event. It helped patients adjust to life after critical illness or injury, guided families through the shock of what had happened and offered compassion. The staff we spoke to told us that support was tailored to everyone's needs and for however long they needed the support.

Feedback received from patients and their families included "They helped me so much and really took the edge off. They gave me lots of tools and help to contact more people that could help me and gave me advice about how to deal with situations." One family member described how following the loss of their son the service was pivotal in their mental health and survival following the tragedy.

Monitoring and improving outcomes

Score

3. Evidence shows a good standard of care

We scored the service as 3. The evidence showed a good standard. The service routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

The service collected patient feedback through the Aftercare team to make changes to methods of care or communication to enhance patient experience. Patient and families were highly complementary about the prompt and effective treatment they received from the service at the time of the incident and following it.

Senior leaders monitored the effectiveness of care and treatment through live dashboards, outcome data and reviewing benchmarking to compare with other similar services; such as cardiac arrest outcomes, paediatric outcomes and regional review of trauma outcomes.

The service had set key performance indicators (KPI), in line with national guidance, which they measured performance against. When compliance fell below the required target they took action to address it. For example, we saw that in 2025 quarter 1 the compliance for antibiotic administration in open fractures was 86% against a target of 90%. Leaders told us that they shared the performance data at the clinical governance day with clinicians, emailed a reminder of the standard operating procedure to remind all staff of the KPI. Improvements were noted in the following quarter, with staff achieving 91% compliance.

The service used the findings to make improvements and achieved good outcomes related to getting patients treatment on time. For example, Post- prehospital emergency anaesthesia (PHEA) hypotension is strongly associated with increased mortality, particularly in trauma patients. A concern was identified regarding the rate of post-PHEA hypotension. As a result the service produced evidence-based clinical recommendations to support improvements, updated the PHEA standard operating procedure (SOP) to strengthen expectations and shared these with the clinical workforce, developed a collaborative research proposal to assess the

impact of plasma transfusion on post-intubation hypotension and initiated a project to evaluate and monitor the improvement of patient outcomes.

The service had systems to monitor and improve outcomes. However, leaders recognised they did not have access to commissioners' performance data to monitor and improve patient outcomes. They worked closely with the local major trauma centre to ensure routine sharing of patient outcomes. The service had started to use the quarterly outcome data to ensure accurate recording of patient outcomes. This meant that the service had more data to inform their practice and drive improvement for outcomes of those they treated.

The service monitored and reacted to avoidable incidents of harm. Learning from investigations was shared with the aim of making improvements, for example, the service modified their policy on the use of heated blankets in patients that were unconscious following a thermal burn to prevent future harm.

Health inequalities are avoidable differences in health outcomes between groups or populations, such as age, health conditions and gender. These impact on physical and mental wellbeing and life chances of individuals and groups most affected. By looking at data, services can provide evidence-based interventions, highlight which communities suffer from worse health outcomes and understand specific barriers faced by under-represented groups. At the time of our assessment, senior leaders told us that they did not review their patient outcome to identify health inequalities for the people they served. However, there was a plan to review this data going forward.

Consent to care and treatment

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. The service carefully explained to patient what their rights around consent were, made sure they fully understood them and always fully respected these when delivering person-centred care and treatment.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service did not have a specific consent policy; however all staff were expected to adhere to their professional body policies on consent. Consent and capacity assessment formed part of the service's mandatory training policy and adherence to this was monitored through audit of patient care records. We reviewed care record audit data which showed consent was documented in 94% of notes reviewed.

Staff completed mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training modules as part of their care certificate completion. Data showed 100% compliance for both modules. The service also required staff to complete consent training, compliance was above 95% for doctors and paramedic staff.

Staff took all practicable steps to give people the appropriate information, support and time to make an informed decision in a way they could understand. Where it was not possible for staff to get valid consent from a patient, the service acted in accordance with legal requirements.

Staff undertook training for patients with cognitive impairment such as dementia so that they understood how to act when a patient did not have capacity to make their own decisions. Data reviewed showed 100% compliance.
Staff had access to interpreters to support patients to give informed consent. We saw evidence of this being used where a patient's first language was not English. Ambulance crew used language line to support the clinical assessment and gain consent for an intimate examination.

Caring

Rating Outstanding 

The service worked with patients to understand and manage risks. Care and support met patients' needs in ways which were safe and supportive, and enabled them to do the things that mattered to them.

When people communicated their needs, emotions or distress, staff could manage this in a positive way, which protects their rights and dignity and maximised learning for the future about the causes of their distress.

We looked for evidence that patients were treated with kindness, empathy and compassion. We assessed the levels of patient's privacy and dignity afforded to patients. We asked patients to tell us

about their experiences, if they were respected, if they understood that they and their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take patient's wishes into account and respect their choices, to achieve the best possible outcomes for them.

At our last assessment we rated this key question outstanding. At this assessment the rating has remained outstanding. This meant that care and support met patients' need.

Kindness, compassion and dignity

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service treated patients with kindness, empathy and compassion in how they respected patient's privacy and dignity. Staff always treated colleagues from other organisations with kindness and respect.

The culture of the service was rooted in empathy. Staff consistently went above and beyond to provide thoughtful, person-centred care that upheld dignity and promoted emotional wellbeing. Staff told us that senior leaders were approachable and respectful. This was further supported by external partners we spoke with who reported that Helimed House senior leaders were invested in being a true partner and were always striving for excellence.

Staff displayed exceptional compassion, actively listening and responding to people's concerns with sensitivity and reassurance, creating an environment where individuals felt valued, safe, and truly cared for. Staff told us that patients who were particularly anxious, who were very young or who had cognitive impairment were able to have somebody familiar with them. Feedback from patients and families was overwhelmingly positive. They said staff treated them well and with kindness.

Patient feedback consistently showed that ambulance crew were discreet and responsive when supporting patients. They took their time to interact with patients and those close to them in a respectful and considerate way.

Examples of feedback received by the service included “The crew ensured I was comfortable before, during and after the journey. Ensuring I was warm and moved gently” and “Everyone was so kind and professional, taking great care of me and putting my mind at ease. Thank you!”.

Staff followed policy to keep patient’s care and treatment confidential.

People were treated with remarkable kindness and respect. Staff built trusting relationships, offering emotional comfort and personalised support that made people feel understood and at the centre of their care. The Aftercare team provided children’s memory boxes to supporting bereaved families containing information, books and keepsakes for families and children recently bereaved.

Treating people as individuals

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service treated patient as individuals and was exceptional in how they made sure patient’s care, support and treatment met patient’s needs and preferences. The service took account of patient’s strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

The service had guidance for caring for people with specific needs, including newborn babies, bariatric patients and acute mental health needs. There was an embedded emphasis on every patient and their family receiving tailored support from the ambulance crew and Aftercare team. We saw evidence of this when a child was taken to a local hospital to ensure the family were together following a road traffic accident. One patient’s feedback included “They explained what I wanted to know without leaving out any details, answering anything I was confused about” and “A lovely lady came to my house to talk me through the situation and answer any questions I had which put me and my brother at ease.”

Staff understood and respected the personal, cultural, social, and religious needs of patients

and how they may relate to care needs. Staff asked patients and their family questions to learn about who they were and if they had any specific physical, emotional or cultural needs.

The Aftercare team created a profoundly supportive environment by connecting patients and their families with others who had lived through similar experiences. Patients described how being introduced to others with shared experiences made them feel understood and emotionally supported, helping them process their journey with greater confidence and reassurance.

Independence, choice and control

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. Where relevant in an emergency service, the service understood the need for people to maintain their independence and be able to exercise their rights to have choice and control over their own care, treatment and wellbeing, as much as clinically possible.

Patient records demonstrated evidence of staff speaking with family to avoid hospital admission which would be unlikely to meaningfully benefit a patient as they were profoundly frail. The assessment was holistic and put the patient's need and wishes as likely outcome at the centre of the decision making. Discussions resulted in community team support the medical management of the patient.

Ambulance crew told us that they promoted choice and independence, where clinically possible. For example, they told us that they transported a young child to a major trauma centre closer to their home address so that the family unit would be closer.

Staff gained relevant past medical history to support decision making and offer choice. For example, we saw evidence of gaining information on patient's cultural background and consideration for limitation in treatment such as not transfusing blood products.

Responding to people's immediate needs

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The staff were exceptional in how they listened to and understood patient's needs, views and wishes. Staff responded to patient's needs in the moment and acted to minimise any discomfort, concern or distress.

Staff listened and responded to patient's needs, views and wishes. Where there were barriers, staff had access to tools to ensure that they understood the patient's needs to act and minimise concern or distress. Ambulance crew could access specialist equipment to meet patient's specific needs. For example, vehicles were stocked with specialist equipment to provide roadside mechanical ventilation both adults, children and babies.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and their families were exceptionally complementary of the support given by staff not only on scene but during the follow up also.

Patient feedback results from February 2025 to March 2026 scored an average of 4.98 out of 5 for being made comfortable and 4.89 out of 5 for responding and managing pain.

We saw how support was offered by ambulance crew to other young family members that had witnessed a cardiac arrest. They were given trauma teddies and were included in discussions and given an opportunity to ask questions.

Workforce wellbeing and enablement

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service cared about and promoted the wellbeing of their staff and was exceptional at supporting and enabling staff to always deliver person-centred care.
Staff had access to resource and facilities for safe working. This included being able to take breaks, designated rest areas, rooms to stay following a shift to ease psychological fatigue, and access to drink and food out of hours.

Staff were able to provide feedback, raise concerns and suggest ways to improve the service or staff experiences and could expect a response. There were 3 staff network groups, “Refuel” which focused on staff wellbeing, working dads and a more recently set up neurodiversity group. Staff networks consulted on the review of the service’s parental leave policy.

Senior leaders embedded an exceptional culture of compassion by placing staff psychological wellbeing at the forefront of the service’s values. Following traumatic missions, leaders ensured crews were supported through structured cold debriefs with external partners, creating safe spaces to reflect, process emotions, and feel genuinely cared for.

Leaders demonstrated deep insight into the emotional toll of the work. They were acutely aware when crews had attended multiple traumatic incidents in a single shift and encouraged them to step down, rest, and recover before redeploying—reinforcing a powerful message across the service that “it’s OK to not be OK.”

Staff consistently told us they felt understood, protected, and valued. Every member of staff we spoke with knew exactly how to access both internal and external wellbeing support, reflecting a culture where emotional safety was prioritised as highly as operational safety. Teams worked and where relevant learnt together to develop multidisciplinary working. For example, the pilots completed their bullying and harassment and level 1 and 2 safeguarding training through East Anglia Air Ambulance.

Staff had access to personalised support which recognised the diversity within the workforce. We saw evidence of reasonable adjustments made to support staff perform their role and in line with the Equality Act 2010. The service had a Finding the Balance Policy which supported staff improve well-being by reducing stress, burnout, absenteeism while enhancing work-life balance. In the last 12 months 8 requests had been made. We reviewed 3 approved by the human resource team.

Staff felt valued by their leaders and their colleagues. We observed motivational, respectful and kind interactions amongst all staff during our visit. Leaders monitored workforce statistics to monitor turnover. When staff left, they conducted exit interviews to improve employee satisfaction and retention.

In 2023, the service carried out 2 staff surveys and developed an action plan to address identified themes. These included more healthier options in the vending machine, electric charging points in the car park and more confidential working spaces.

Critical care paramedics were supported through multiyear development pathways, and the service invested heavily in clinical governance to maintain high standards. Staff told us they felt well supported, and there was a clear focus on wellbeing as part of the organisation's culture.

Responsive

Rating Outstanding

We looked for evidence that patients and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of patients and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that patient could access care in ways that met their personal circumstances and protected equality characteristics.

At our last assessment we rated this key question outstanding. At this assessment the rating has remained outstanding. This meant patient's needs were met through good organisation and delivery.

Person-centred care

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service was made sure patients were at the centre of their care and treatment choices and they decided, in

partnership with patients, how to respond to any relevant changes in their needs.

Ambulance crews had limited information on arrival to a patient but worked in partnership with the NHS critical care desk and other paramedic colleagues on scene to assess, respond and treat patients. Due to the nature of the missions and patient conditions patient choices regarding their care and treatment were not always possible. However, review of patient records showed that ambulance crew always opted for the least restrictive practice in the interest of the patient. For example, we saw that ambulance crew decided not to fully sedate a patient whilst transferring them as the patient was more coherent and not in the patient's best interest.

The service had policies and procedures to support patients with complex healthcare needs, sensory loss, mental health, learning disabilities and dementia. Staff completed mandatory training to support patients whilst providing care and treatment.

Staff were aware that some patients aged between 16 and 18 years of age were children and adapted the service to take account of this. For example, they used trauma teddies to support assessment, and we saw policies referencing guidance specific to children.

Feedback received by the service showed that those close to the wherever possible the patient or their family were kept involved in the care and treatment. The Aftercare team were pivotal in coordinating the support after the initial incident and offered ongoing communication and support.

Care provision, integration and continuity

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service met the care needs of patients and their local communities, so care was joined-up, flexible and supported choice and continuity.

Emergency and urgent care

Helimed House aimed to operate a 24-hour, 7 day a week service to efficiently cover the Norwich area by either car or air ambulance. Where this was not possible due to staffing or adverse weather it was covered by the East Anglian Air Ambulance (EAAA) Cambridge airbase. The service conducted mission reviews and analysed data to ensure that operations were as responsive as possible. The service had strong links with other emergency services to ensure the strong integration and continuity of care.

The service demonstrated an exceptional understanding of the needs of local people and the communities it served. Care was thoughtfully planned and delivered in ways that were shaped by local priorities, ensuring support was both relevant and genuinely responsive.

Leaders worked proactively with a wide range of system partners and community organisations, meeting regularly with charities, local police liaison officers, and other stakeholders to understand emerging needs and tailor care accordingly. This collaborative approach strengthened relationships across the system and ensured that care pathways were aligned, coordinated, and accessible.

The Aftercare team played a pivotal role in this integrated model. They engaged with multiple charities to enhance and refine signposting options for patients and their families, ensuring people received timely, personalised support beyond the immediate episode of care. This commitment to partnership working meant individuals were connected with the right help at the right time, reinforcing a culture of compassionate, community-centred care.

The service had systems to help support patients in need of additional needs or specialist intervention. The service ran quarterly patient forum groups to gain feedback about the service they provided. Feedback showed that people were impressed at how the teams had looked after their family members, particularly children, at the time of the accident.

Helimed House welcomed any visitors to their Norwich base and had a dedicated room for patients and their families within the entrance of the building in acknowledgment that there may be a huge emotional and psychological impact when visiting for the first time following their care.

Deployment of Helimed House ambulance crew was made by the NHS ambulance critical care desk. This meant that at times ambulance crew may be stood down or redirected if there was a greater need. The service reviewed data related to shifts which over ran to ensure that this was

prevented to protect the service and it's staff. In the 6 months prior to our assessment there were a total of 6 occasions where an ambulance crew member could not work their planned shift due to an overrun. This totalled 470 minutes (0.18% of total shift time over 6 months).

Providing information

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. The service usually supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

Information was available on the services website, it hosted a wide range of information such as patient support, clinical research and details of the charity. The service displayed its mission figures on their public website to demonstrate how it was serving its community and the type of incident they were called to, such as medical emergency, cardiac arrest or road traffic collision.

Patients and families reported that staff were clear when explaining next steps during their care and during the follow up meetings after the incident. They felt well informed and had opportunity to meet to seek clarification or ask questions regarding their care or seek further support regarding what they had been through.

Aftercare care card or bereavement cards were left by Helimed House ambulance crew to enable patients and their families to contact the Aftercare team for further advice and support should they wish to. During the time of our assessment, managers told us that they did not have information available in other languages but acknowledge there was a need to have more accessible resources available. Information could be provided in other languages if required for individuals. The service had access to interpreters through language line to support translation where English was not a first language.

Staff told us that where possible they included patients and their families when explaining

treatment and care they would be providing before they carried this out. If there was a language barrier staff knew how to access support on their devices or asked other adults on the scene to help them communicate most effectively.

Patient feedback we reviewed demonstrated that the service encouraged patients and their families to ask questions and these were responded to openly and honestly. Where care fell short of the expected standard, the service ensured that this was communicated at the most appropriate and opportune moment.

The service did not implement the accessible information standard (AIS) to their service. This meant that they were not always identifying, recording, flagging, sharing, and meeting the communication needs of patients with disabilities or sensory loss. Senior leaders acknowledge that there was work to be done to address this.

Listening to and involving people

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service enabled patients to share feedback and ideas, or raise complaints about their care, treatment or support. Staff involved patients in decisions about their care where able and told them what had changed as a result.

The service had received a total of 45 complaints in the last 12 months. The majority related to fundraising. We saw evidence of an apology and action taken to address complaints relating to any clinical staff. The service understood the importance in maintaining good relationships with local hospitals to provide a high level of care to the patients of the counties they served.

The service placed a strong emphasis on listening to patients and families, using their feedback to drive continuous improvement. Feedback was gathered through quarterly patient forums, direct contact with the Aftercare team, and patient surveys—ensuring people had multiple, accessible ways to share their experiences. Where English was not the first language spoken

they used language line to ensure that feedback was captured accurately.

Patients and families were actively encouraged to contribute ideas, and the open-ended nature of Aftercare support meant individuals could reflect and provide feedback months or even years after their care. This created a rich, ongoing source of insight that shaped service development and strengthened patient-centred practice.

We saw evidence of feedback given to patients on action taken in response to their experience or care. For example, a patient had sustained a thermal burn following the use of a heated blanket. The service took immediate action by removing the product from use, had used their channels to update other services in the region who use the same device and informed the Medicines and Healthcare Products Regulatory Agency (via a system called “Yellow Card”) which collects data on all UK healthcare products and issues alerts nationally. This was all communicated to the patient to demonstrate that action had been taken.

The service had a complaints policy which covered all types of complaints such as patient care, fundraising or aviation. The policy outlined how complaints would be dealt with and by whom and aimed to respond to all complaints within 5 to 10 working days of receipt depending on the complexity. There were clear escalation processes if the complainant was not satisfied with the initial response.

Senior leaders told us that complaints regarding clinical care were very rare but took those as an opportunity to listen and improve. Staff were informed of feedback at team meetings and monthly clinical governance group meetings. The service had received 1 complaint regarding clinical care in the last 12 months and therefore had not made any changes in response to patient feedback.

Equity in access

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service ensured

patients could access the care, support and treatment they needed when they needed it.

There were no barriers to patients accessing the service. It was tasked by the local NHS ambulance critical care desk and there was no discrimination as to who received the service, ensuring equity in access for everyone.

The 2025 data we reviewed showed an exceptional standard of service for patients. Helimed House had completed 750 helicopter taskings and 601 RRV taskings attending to trauma and medical patients both paediatric and adult. The responsiveness of the service and ability to deliver enhanced care such as blood transfusions to 71 patients in 2025 gave every patient the best possible chance of surviving.

Staff completed equality, diversity and inclusion training as well as training such as autism, dementia and learning difficulties. Staff we spoke to understood what reasonable adjustments may need to be made when treating patients with protected characteristics. Policies and procedures were in place to ensure that people had equal access to care, treatment and support. At the time of the assessment, we were told the service did not have a specific equality, diversity and inclusion policy but this had been discussed at the people committee meeting in February 2026 prior to our onsite visit. Action had been taken to develop a policy. The service was also aware that they had not applied a risk matrix to ensure they identified potential discrimination.

Managers and staff worked closely with system partners to make sure patients were transferred to receiving hospitals in a timely manner and handed over to the receiving consultant at the hospital. The time to handover data was monitored by leaders to ensure that ambulance crew were not unnecessarily held up and were ready for redeployment if required.

The Aftercare team contacted all patients and families by telephone to offer support and advice to ensure equal access for as long as they wished.

Equity in experiences and outcomes

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. Staff and leaders listened to information about patients who were most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

The service had systems to monitor outcomes. In 2025, the service had an agreement with the local major trauma centre to ensure routine sharing of patient outcomes. This meant that the service had more data to inform their practice and drive improvement for outcomes. Senior leaders told us that they would use this data going forward to identify potential health inequalities within the population they served.

The training suite had a variety of mannequins designed to reflect differing ethnicity and congenital conditions to simulate real life situations in training environments for staff to improve experience and outcomes.

People who did not speak English as their first language could access the service. Staff had access to interpretation services by telephone. There was a range of pictorial information to assist staff in engaging with people who had additional needs.

The service worked with a local school in Norwich to educate and improve outcomes in cardiac arrest. Helimed House staff taught CPR training to sixth form students who would in turn teach younger students at the school.
Senior leaders acknowledged that they did not collect data to understand the breadth of diversity of the population it served to adapt care to meet the diverse health and care needs for all patients. The collection of such data would allow the service to highlight potential gaps in case and tackle any unconscious bias.

Planning for the future

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. Patients were given support to plan for important life changes, so they could make informed decisions about their future, including at the end of their life.

Patients were supported to make informed choices about their continuing needs. Their family or carer was involved if they wished. We saw evidence of ambulance crew involving a family member in the options for the patient treatment, this was patient centred and reflected the frailty and unlikely benefit of taking the patient to hospital.

Staff reviewed patient's care plans, information about their wishes and used these to make informed decisions when tasked to support the local NHS ambulance service.

Staff made sure that the Aftercare team card or bereavement card was provided to patients or their families following care or treatment by the team discharging them to access further support following the incident.

Well-led

Rating Outstanding

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of patients who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

At our last assessment we rated this key question outstanding. At this assessment the rating has remained outstanding. This meant patient's needs were met through good organisation and delivery.

Shared direction and culture

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service had a clear shared vision, strategy and culture that built on the organisational vision and strategy. This was based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and an exceptional understanding of the challenges and the needs of patients and their communities.

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The service had a 5-year strategy with the strategic intent 'Together with our supporters, we will push the boundaries in pre-hospital emergency medical care to measurably improve patient outcomes across East Anglia'. The strategy was based upon 3 strategic themes underpinned by key enablers to achieve the 5-year goal. There was a focus on 'raising the ceiling, not the floor and how to develop values for the future that were meaningful.

The current strategy was 4 years old and senior leadership told us that they were currently reviewing it to develop a new one to meet the changing needs locally. The new draft strategy outlined East Anglian Air ambulance (EAAA) service's purpose 'Pioneering life-changing care. Powered by people. Always ready'. These were supported by strategic drivers that the leadership team would focus their time and resource on over the next 5 years. These were aligned to behaviours so all staff could operate as a team to deliver on the planned service purpose and strategy.

Staff appraisal questions were based on the values of the charity values 'RAISE'; Reasoned, Accountable, Integrity, Synergy and Evolution. Employee behaviours were linked to the organisational values which transformed the abstract principles to concrete actions connected to everyday tasks to achieve the broader mission and purpose 'Pioneering life-changing care, powered by people, always ready'. Staff were consistently focused on the needs of patients receiving care and delivering a high quality of service.

The service had an open culture where patients, their families and carers as well as staff could

raise concerns without fear. The service were continuously reviewing learning from incidents, complaints and missions to address shortfalls. There was a strong emphasis on creating a working environment that allowed all staff to make suggestions and comments to drive improvement. This was supported by both clinical and non-clinical staff we spoke to, as well as action taken by senior leaders. For example, we saw incidents were reviewed and where necessary equipment was taken out of use and learning was shared across other services to prevent future harm for all patients.

Staff felt respected, supported and valued by the leadership team and each other and described an inclusive culture. Relationships between staff were positive, with strong teamwork and collaboration.

The service had a recognition policy which supported staff to be recognised for their achievements. Team and individual staff achievement, and success was recognised and celebrated by the charity commendation for excellence in work or demonstrated a set of behaviours that supported the charity values, which is above and beyond that expected of their role. The service held 2 main recognition events a year to thank staff for their work
The service did not have an equality, diversity and inclusion policy at the time of the assessment. However, staff we spoke to told us that leaders promoted equality and diversity in daily work and provided opportunities for career development.

Capable, compassionate and inclusive leaders

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They always did so with integrity, openness and honesty and understood the impact their behaviours and leadership had on patient outcomes and experience.

The registered manager and nominated individual were highly experienced and qualified for their roles. They understood the importance of robust systems, health care regulation and support to achieve safety and positive outcomes for the patients they served.

Leaders understood and managed the priorities and issues the service faced. Leaders were visible and approachable in the service for patients, stakeholders and staff. Staff felt the leaders supported them to develop their skills and felt comfortable raising concerns.

Leaders took incidents seriously and knew how to deal with concerns when raised and promoted a positive culture of learning in the service. Leaders undertook patient facing activities to assess for themselves how the service was running. The registered manager worked frontline alongside clinical staff and encouraged reviews of complex case by wider team displaying the openness and honest expected within the organisation.

Staff were invited to team meetings and could directly access the registered manager to ask questions or make suggestions. Information was cascaded to staff via team meetings, monthly temperature checks, clinical governance and committee meetings. However, staff told us that they were able to meet outside of the structured meetings if needed.

Staff and patient survey results were acted upon for example following the 2 staff surveys in 2023, leaders developed an action plan which was shared with staff on how they were committed to act on their feedback. We saw progress against actions and where actions were in progress there was detail on the action required with named individuals accountable for each action.

Freedom to speak up

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. The service fostered a positive culture where patients knew they could speak up and their voice would be heard.

Freedom to Speak Up (FTSU) is generally not legally required for all charity organisations, as it is a specific framework designed for NHS and healthcare-related bodies in England to foster a culture of raising concerns. However, the principles behind it, safe whistleblowing and reporting are highly recommended for all charities to ensure proper governance and accountability. The service had 1 FTSU guardian in post since 2025. There was a plan to have a deputy FTSU to provide additional level of support and resilience for the guardian.

Staff and leaders acted with openness, honesty and transparency. Staff were encouraged to raise concerns and offer ideas; the culture allowed staff to be confident their voices were heard.

Staff told us when they had raised valid concerns or felt they would be able to, were or would be supported, without fear of detriment. The service held a consultant away day to review the culture and working relationships as a team. Staff were encouraged to be vulnerable, open, respectful and curious. Actions were taken from the day to sustain the progress made and these were followed up after 3 months and measured through an anonymous 360 feedback questionnaire completed by staff. Feedback from consultants and paramedics was positive.

Senior leadership communicated a ‘Can we do business better’ mindset. It gave clinical staff the opportunity to feedback to leaders and make suggestions. For example, staff were consulted on changes in policy and future purchasing of clinical equipment to ensure that all staff were involved in improving quality of care and innovation within the service to benefit patients and staff.

Patients, their families and carers were provided with information to explain how they could raise a concern and how this would be investigated. Senior staff were encouraged to respond to immediate concerns or complaints with a view to resolution. There were policies to support the complaints process, we saw evidence of action taken to complaints made in line with policy.

We reviewed information which showed there had been 1 matter raised via the speaking up process in the past year. At the request of the person who spoke with the guardian no further action was taken in relation to staffing and workforce planning decisions.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

We scored the service a 3. The evidence showed a good standard. The service valued diversity in their workforce. Staff work towards an inclusive and fair culture by improving equality and equity for everyone.

The service did not have an equality, diversity and inclusion (EDI) policy in place at the time of the assessment. We saw the equal opportunity statement, developed in September 2023 which ensured equal opportunities, fairness of treatment, and elimination of all forms of discrimination in the workplace.

The service had recently appointed a new Director of People and Culture and there was a commitment to develop an EDI strategy and policy. The service gathered and analysed equality and diversity data to ensure that they achieved the diversity and inclusion aims and commitments, as set out in the Equal Opportunities Statement. An executive leader told us there was a need to support and address diversity within the workforce to represent all the community they served and make it accessible for people to join. Leaders acknowledged the new strategy, and policy would ensure a robust system to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment.

Staff told us they had opportunities to apply for project work, new roles and to undertake external studies through an open application process.

The service acted to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality Act and those from excluded and marginalised groups. Leaders took appropriate action to address reported behaviour or attitudes which were negative in style. We saw evidence of this during our assessment.

Staff with disabilities were offered reasonable adjustments to support them to carry out their

roles well. As part of Neurodiversity celebration week, staff were invited to a 1-hour online workshop focussed on promoting and supporting neurodiversity in the workplace.

Staff led on service improvement ideas. For example, staff led on conducting market research, selection and trials by staff to purchase a single ventilator that would provide appropriate ventilation strategies to patients.

Governance, management and sustainability

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service had clear responsibilities, roles, systems of accountability and effective governance. Staff used these to manage and deliver high-quality, sustainable care, treatment and support. Staff always acted on the best information about risk, performance and outcomes, and shared this securely with others when appropriate.

The service operated effective governance processes through various committees and on-site activities. There were clear responsibilities among staff which interconnected and ensured governance was fundamentally strong. The service used data and best information to ensure it understood its risks, performance and outcomes. Senior leaders managed performance well and took appropriate action to managing risk. For example, clinical staff attended morbidity and mortality meetings at the local NHS trust. Incidents of out of hospital cardiac arrest were discussed with the intention of reviewing practice and potential improvement such as decision making and communication.

There was a range of information collected, monitored and communicated internally at the relevant committee meetings and was fed upwards to the board of Trustees. These were evidenced in meeting minutes we reviewed.

Performance data was consistently analysed and compared within the provider organisation and where improvements were needed at the location level, action plans were developed to

make this happen.

Staff at all levels were clear about their roles and accountabilities. Staff had job descriptions, and these set out expectations and responsibilities. The executive team had a current action log which clearly detailed designated staff tasks related to the overall governance of the service.

Staff could find the data they needed, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Leaders understood their roles and responsibilities in providing data and notifications to external organisations. It provided information and reports to external bodies, including the Care Quality Commission (CQC), NHS ambulance service and Medicines and Healthcare Products Regulatory Agency following a thermal burn. The service provided feedback and shared information with external clinical forums and system partners to ensure it was up to date with best clinical practice. System partners told us that the service were supporting them to be effective in their delivery of safe care.

Leaders made sure that accurate information was discussed and shared with key staff. For example, when the new digital governance system was developed, there was a clear roll out of training and QR code for staff to offer feedback, with clear objectives on how the system will support different functions of the organisation.

Risks were clearly identified and a formal log of these was used to keep oversight and manage mitigations and/or bring to resolution. Staff contributed to decision-making to help improve sustainability and improve quality of care.
Audit processes, research and the outcomes were used to ensure quality of services was maximised. Where improvements were required, leaders ensured action plans and the monitoring of these led to positive changes, for example staff were reminded of the importance of delivering timely antibiotics in open fractures where compliance fell below the target of 90%.

The service had plans to cope with unexpected events and had a business continuity plan, which included major incident plans.

The service had not reported any data breaches and systems were secure. Patient identifiable information was handled correctly.

We reviewed several service level and provider policies and found these were up to date and readily available to staff. There was leadership oversight of the accuracy and validity of each policy. However, policies were not subject to equality impact assessments to ensure they did not disadvantage people with protected characteristics or those who were more vulnerable.

The service had a detailed risk register which identified, assessed and prioritised clinical, financial and operation risk to improve patients' safety and organisational performance. It tracked mitigation actions and was supported by policies to ensure transparency, regulatory compliance and inform decision making. The board of Trustees were informed of changes to the risk register for review and oversight. Top 3 risks during our onsite assessment included the recruitment and deployment of advanced critical care paramedics, IT infrastructure and risk of cyber-attack and impact on service and the administrative workload for maintaining readiness for CQC assessments as the medical director also acted as the CQC registered manager with no specific administrative support for CQC activities.

Executive leaders and trustees were sighted on the increased costs per mission due to the supply chain demand. There was a clear strategic focus on fundraising to ensure a sustainable service. The new strategy gave consideration for the need to future proof donations as the charity was dependent on income generation and the charitable funds. The service aimed to continue to be identified as an area of excellence to recruit the best staff to support the delivery of high-quality care.

Partnerships and communities

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service clearly understood and carried out their duty to collaborate and work in partnership, and services worked seamlessly for patient. Staff always share information and learning with partners and collaborate for improvement.

Staff and leaders at the service collaborated with relevant external stakeholders and agencies

to improve care and treatment for patients using the service. For example, they communicated workforce changes within the service and shared reporting templates with other providers to promote consistency across air ambulance emergency service (HEMS) providers.

The service met with external stakeholders and regional networks to understand the needs of the community and the provider ambitions. Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. For example, the service committed to addressing the disparity between women receiving Cardiopulmonary Resuscitation (CPR) in comparison to men. They led on media coverage for training with female manikins, provided blogs and resources, worked with charities and resuscitation organisations to improve out-of-hospital cardiac arrest (OHCA) survival in the region.

The service met quarterly with other regional air ambulance services and the contracted NHS ambulance trust to review clinical and operational updates and performance. This aimed to improve care coordination, enhanced network collaboration and offered opportunity to discuss any local or national updates.

The senior leadership were supporting new hospital programs on the construction and design of new helipad infrastructure as well as supporting regional trauma networks in improving treatment on scene through robust effective pathways such as stroke and silver trauma. This in turn would support the critical care desk to deploy the HEMS services to correct missions.

Learning, improvement and innovation

Score

4. Evidence shows an outstanding standard of care

We scored the service a 4. The evidence showed an exceptional standard. The service had a strong focus on continuous learning, innovation and improvement across the organisation and local system. Staff often encouraged creative ways of delivering equality of experience, outcome and quality of life for patient. Staff actively contributed to safe, effective practice and research.

The research, audit, innovation and development (RAID) team supported the service in its vision to improve patient outcomes by developing new treatments, equipment and skills through trials, extensive research and using the latest innovation evidence in Pre-Hospital Emergency Medicine (PHEM). It collaborated across UK air ambulances, the NHS and universities to improve the field of PHEM. Staff had attended various UK and international events where they shared learning from these initiatives with other HEMS.

The RAID team met weekly to discuss audit data and feedback to monthly governance steering group to identify themes and trend and drive improvement in performance and clinical outcomes.

The service led innovative research to support early diagnosis and treatment in patients. Studies such as ERICA-Arrest and BRAIN-FIRST projects were examples of how the service was striving for innovative research to drive improvement in the quality of PHEM.

The service had a quality improvement (QI) methodology and there were examples of QI in practice. Staff told us that they were actively encouraged to be a part of quality improvement projects. The service evidenced current QI projects and their effectiveness such as Direct to CT pathway for EAAA trauma patients taken to a NHS hospital.

Staff were committed to continually learning and improving services. Clinical staff were fully engaged with research to save lives. Staff described it as part of the ethos of the organisation they worked for and was a part of their values.

There were processes for learning when things went wrong and recognising good practice, either locally or nationally. All projects for research were reviewed through the clinical governance steering group. Projects were triggered in several ways such as changes in best practice standards, new technology as well as clinical performance and staff wanting to develop best practice. For example, research had identified patients with a low blood pressure in cardiac arrest were less likely to survive. As a result, the service used invasive technology to monitor patient's vital signs in real time to respond to any deviation immediately to reduce patient harm and improve patient outcomes.

Leaders supported staff to have the time to develop their skills around improvement and innovation and to pursue areas of interest and research within the service. Projects for research

were triggered in many ways such as current best practice standards and new technology. Leaders encouraged innovation and participation in research, and we heard about the following examples including consulting on the replacement of new ventilators and saw evidence of feedback from clinical staff on their functionality during the trial period. The service had coproduced a bespoke bracket to enable the ventilator to be securely stored on board the air ambulance.

Staff and leaders were committed to excellence that centred on the patient experience and best outcomes from lifesaving treatment. In 2024/2025 the service received 82 clinical feedback forms from patients and their families scoring 5 out of 5 for satisfaction with the treatment they received. They received 63 Aftercare feedback forms covering 3 key questions about the support received with an overall satisfaction of 4.82 out of 5. The service told us that they have not needed to make any changes to their service in the last 12 months in response to patient feedback. However, they were continuing to collect and analyse data to identify where improvements could be made based on patient experience.