Broughton Park Ambulance Services Ltd

Broughton Park Ambulance Services Ltd

Quality Report

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

Ratings

Overall rating for this ambulance location	Requires improvement
Emergency and urgent care services	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Broughton Park Ambulance Services Ltd provides emergency and urgent care services.

We inspected this service using our new phase inspection methodology. We carried out the announced part of the inspection on 4 September 2018.

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

Throughout the inspection, we took account of what people said about the service and how the provider understood and complied with the Mental Capacity Act 2005.We found the following issues that the service provider needs to improve:

- Although the service assessed, and managed some risks accordingly, other risks were not always identified or responded to in the right way.
- Despite having access to national guidance, we had no assurance that care was always provided in line with it and documented clinical pathways outlining these processes were not in place at the time of our inspection. In the days following our inspection documentation was produced but this was not sufficiently aligned with national guidance.
- Although the service had managers in place to run the service, we were not assured that they had sufficient understanding of regulation relating to fit and proper persons and governance at the time of our inspection.
- Some formal governance processes to support the delivery of clinical care had not been identified as necessary or implemented by managers.
- The service generally gave, recorded and stored medicines well. However, not all medicines were stored and administered correctly.

We also found the following areas of good practice:

- The service had a system for reporting, reviewing and investigating incidents.
- Staff received training as part of their role and the majority were up to date.
- The service had safeguarding systems and processes in place to help staff identify safeguarding concerns and protect people from abuse.
- The maintenance and use of facilities and equipment kept people safe.
- The service had enough staff with the right skills and training to keep people safe and to provide care and treatment. The service made sure staffs were competent in their roles as responders. They received appropriate training and understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005.
- The service kept appropriate records of patients' care and treatment and had access to appropriate levels of pain relief.
- The service monitored response times to help make sure they reached people as quickly as practicable. They monitored some outcomes and used findings to improve care for patients.
- Staff cared for patients with compassion, providing emotional support to patients to minimise their distress. Patient feedback confirmed they were treated well and with kindness. They involved patients and those close to them in decisions about their care and treatment.
- The service provided care that reflected the needs of the local population and took account of people's individual needs. People could access the service when they needed it. Response times were monitored so that the service could ensure care was provided in a timely way.
- The service treated concerns and complaints seriously and had a policy in place for investigating and learning lessons from the results.
- The service promoted a positive culture that supported and valued its staff. Staff held extreme pride for being members of the service.

Summary of findings

- The service had a vision for what it wanted to achieve and plans to turn it into action, with a systematic approach to continually improving the quality of its services.
- The service engaged well with patients and staff to plan and manage services effectively.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected emergency and urgent care services. Details are at the end of the report.

Ellen Armistead

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Emergency and urgent care services	Requires improvement 	We rated the service as requires improvement because: • The service assessed and responded to some risks and managed these well, but other risks were not identified or responded to in the right way. • Some, but not all medicines were stored and administered correctly • Despite having access to national guidance, we had no assurance that care was always provided in line with it. • Some formal governance processes to support the delivery of clinical care had not been identified as necessary or implemented by managers. However, we saw some good practice which included: • The service had a system for reporting, reviewing and investigating incidents • We saw joint working with the local ambulance service NHS trust to provide regular training and use of the safeguarding referral system • The service monitored response times to help make sure staffs reached people as quickly as practicable • Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005. • Staff cared for patients compassionately. Patients said they treated them well and with kindness. • The service provided care that reflected the needs of the local population and took account of peoples' individual needs. • People could access the service when they needed it. Response times were monitored so that the service could ensure care was provided in a timely way.

Summary of findings

• The service treated concerns and complaints seriously and had a policy in place for investigating and learning lessons from the results.

• The service promoted a positive culture that supported and valued its staffs. Staff held extreme pride for being members of the service.

• The service had a vision for what it wanted to achieve and plans to turn it into action

• The service used a systematic approach to continually improve the quality of its services

• The service engaged well with patients and staffs to plan and manage services effectively.

Requires improvement

Broughton Park Ambulance Services Ltd

Detailed findings

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Detailed findings

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Background to Broughton Park Ambulance Services Ltd

Broughton Park Ambulance Services Ltd is an independent ambulance service in Manchester. The service serves the communities of Prestwich, Broughton Park and Whitefield in Manchester. The service was first registered in June 2017. It is based on a model used in similar organisations both in the UK and worldwide, known as Hatzola. Hatzola means “rescue” or “relief” in Hebrew.

Patients served by the service may be suffering with minor to major illness or injury. The service is wholly funded by a Manchester based beneficiary. It is run by locally trained staff from the Jewish community who are volunteers.

Broughton Park Ambulance Services Ltd operates 24 hours a day, 365 days a year, providing an immediate response to local medical emergencies.

People access the service by ringing a dedicated telephone number (an alternative to 999), which is advertised locally. Staff in their own cars and ambulance vehicles are dispatched using radio systems. Response times are monitored.

There are currently 35 responders and four call handling staff known as operators, who answer calls and dispatch responders. Three responders are also known as coordinators. Coordinators have a senior role where they monitor the radio on an ad hoc basis, offer advice to responders on scene, and can be called to attend and coordinate incidents involving multiple casualties until emergency vehicles arrive.

Hatzola Manchester has been active since 1980, though Broughton Park Ambulance Services Limited opened officially in 2016 and registered with the Care Quality Commission in 2017. The service had a registered manager in post when the organisation first registered. However, there was an absence of four months between December 2017 and April 2018 following the manager’s departure before a new registered manager application was initiated. The application process was nearing completion at the time of our inspection.

This was our first inspection of the service since it was first registered.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a pharmacist inspector and a specialist advisor; a registered paramedic with significant experience in advanced emergency and urgent care. The inspection was overseen by Nicholas Smith, Head of Inspection (Hospitals).

Detailed findings

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	Requires improvement

Emergency and urgent care services

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice

During the inspection, we visited the ambulance station, meeting base and one of the call operator locations. We spoke with 11 staff including; responders and operators, the medical director, safeguarding lead, and committee members. We spoke with two patients and one relative. During our inspection, we reviewed 25 sets of patient records and three response vehicles.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

Activity (February to May 2018)

- In the reporting period February to May 2018 there were 1348 emergency calls made and 334 patients transported to hospital.

35 staff worked at the service which included responders and call operators.

Track record on safety

- There were no never events reported
- There were no clinical incidents reported
- There were no serious injuries reported
- There were no complaints reported

Summary of findings

We found the following issues that the service provider needs to improve:

- Although the service assessed, and managed some risks accordingly, other risks were not always identified or responded to in the right way.
- Despite having access to national guidance we had no assurance that care was always provided in line with it and documented clinical pathways outlining these processes were not in place at the time of our inspection. In the days following our inspection documentation was produced but this was not sufficiently aligned with national guidance.
- Although the service had managers in place to run the service, we were not assured that they had sufficient understanding of regulation relating to fit and proper persons and governance at the time of our inspection.
- Some formal governance processes to support the delivery of clinical care had not been identified as necessary or implemented by managers.
- The service generally gave, recorded and stored medicines well. However, not all medicines were stored and administered correctly.

We also found the following areas of good practice:

- The service had a system for reporting, reviewing and investigating incidents.
- Staff received training as part of their role and the majority were up to date.

Emergency and urgent care services

- The service had safeguarding systems and processes in place to help staff identify safeguarding concerns and protect people from abuse.
- The maintenance and use of facilities and equipment kept people safe.
- The service had enough staff with the right skills and training to keep people safe and to provide care and treatment. The service made sure staff were competent in their roles as responders. They received appropriate training and understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005.
- The service kept appropriate records of patients' care and treatment and had access to appropriate levels of pain relief.
- The service monitored response times to help make sure they reached people as quickly as practicable. They monitored some outcomes and used findings to improve care for patients.
- Staff cared for patients with compassion, providing emotional support to patients to minimise their distress. Patient feedback confirmed they were treated well and with kindness. They involved patients and those close to them in decisions about their care and treatment.
- The service provided care that reflected the needs of the local population and took account of people's individual needs. People could access the service when they needed it. Response times were monitored so that the service could ensure care was provided in a timely way.
- The service treated concerns and complaints seriously and had a policy in place for investigating and learning lessons from the results.
- The service promoted a positive culture that supported and valued its staff. Staff held extreme pride for being members of the service.
- The service had a vision for what it wanted to achieve and plans to turn it into action, with a systematic approach to continually improving the quality of its services.
- The service engaged well with patients and staff to plan and manage services effectively.

Are emergency and urgent care services safe?

Good

Incidents

The service had a system for reporting, reviewing and investigating incidents that occurred day to day. An up to date incident reporting policy helped staff understand their responsibilities.

They told us how they could raise concerns and record incidents, concerns and near misses using paper forms which were submitted to managers for review.

Between June 2017 and July 2018 staff reported seven incidents. Six incidents related to vehicle damage and one related to the conduct of a staff member in the back of a vehicle whilst travelling under emergency conditions.

Incidents were reviewed monthly during committee meetings. Following investigation, learning was shared with staff during bi-weekly training sessions, or via private group social media messages or newsletters.

The service had an up to date duty of candour policy which helped outline the process for staff should it require implementation. The duty of candour is a legal duty to inform and apologise to patients if mistakes in their care have led to significant harm. Staff also received training sessions to help make sure they fully understood the responsibilities.

As no incidents involving patients had been reported, the service could not provide us with any instances where the duty of candour requirements had been triggered. Despite this, staff explained its basis and their responsibility to be open and honest when providing care and treatment to patients.

Mandatory training

Staff completed mandatory training as part of their role with the service. Training was a mixture of e-learning and face to face sessions which were completed in partnership with the local ambulance service NHS trust.

This meant staff were provided with training that healthcare staff in the neighbouring NHS trust could access.

Emergency and urgent care services

The details below show the percentage of staff that had completed training in each topic, in July 2018.

Health, Safety and Welfare - 68%

Conflict Resolution - 59%

Resuscitation - 47%

Infection, Prevention and Control level 2 - 56%

Information Governance - 44%

Equality, Diversity and Human Rights - 74%

Safeguarding Adults and Children level 2 - 100%

Resilience - 38%

Freedom to Speak Up - 44%

Health and Well Being - 41%

Prevent - 53%

Counter Fraud - 41%

Waste Management - 38%

At the time of inspection, managers confirmed that figures had increased overall, with 91% of staff now trained in all topics. Three members in total had training outstanding with the rest up to date.

They also told us that the percentages started at zero each January and were based on a trajectory of reaching 100% by the end of each year. Based on the figures at the time of the inspection the manager was confident that staff would complete the required training. We saw reminders issued in minutes of monthly meetings to help make sure this was the case.

Safeguarding

The service had safeguarding systems and processes in place to help staff identify safeguarding concerns and protect people from abuse, neglect, harassment and breaches of their dignity and respect.

Staff used a policy and a safeguarding procedure which helped identify adults and children at risk, and make appropriate referrals.

Referrals were made using a process supported by the local NHS ambulance trust. Here, staff accessed the same reporting systems as trust staff to make the referral.

All staff received level two safeguarding adults and children training. At the time of our inspection, 100% of staff were trained. Training covered topics such as child sexual exploitation, human trafficking, pressure ulcers and neglect, hate crimes and female genital mutilation.

The service had one level three trained staff and access to a level three trained member of staff 24 hours a day via the local NHS trust safeguarding reporting system. A level four trained member of staff was available via the local NHS trust should this be required.

Cleanliness, infection control and hygiene

The maintenance and use of facilities and equipment kept people safe.

The areas we inspected including three vehicles, responder cars and storage areas were visibly clean and tidy. Items including equipment were stored in an organised way both on vehicles and in storage areas.

All the vehicles had designated bins (sharps bins) available for the safe disposal of needles and other sharp objects. Staff we spoke to knew how to dispose of waste into larger bins. The service had a contract with a commercial company who emptied these monthly. Despite this the sharps bins we saw were not labelled to identify what date they were placed on each vehicle. Given that staff told us sharps boxes were disposed of every four months, this meant they could not accurately define when the boxes should be removed.

Hand gel and decontamination wipes were available (chlorine based) on each vehicle. We also saw personal protective equipment was available on all vehicles including aprons, gloves and goggles.

Environment and equipment

Staff were equipped with the right equipment, including mobile phones, digital radios and medical equipment including hand sanitiser, gloves, aprons, jackets, helmets and defibrillators.

All the equipment we reviewed was within expiry date or the required date for portable electrical equipment testing. Checklists we reviewed showed that appropriate checks were in place day to day. One vehicle was equipped to convey bariatric patients.

Emergency and urgent care services

Operators used landline telephones from two providers which provided resilience should one fail. Further resilience was provided with additional mobile phones from different mobile phone providers.

Vehicle keys were stored securely with key codes shared amongst only amongst responding staff to maintain security.

Assessing and responding to patient risk

Call operators understood the need to provide emergency medical advice over the telephone for certain conditions, which they were not trained to provide. For this reason, operators used a written protocol instructing callers to replace the handset and dial 999 for the following conditions: cardiac arrest, seizure, choking, or unresponsive patients. This enabled callers to receive advice whilst help was being arranged both by staff and the local ambulance service NHS trust.

Following arrival at scene, responders took a range of baseline clinical observations to help identify any early signs of deterioration in a patient's condition and act quickly to ensure they received the care they required.

Staff checked whether patients suffered with any allergies which helped mitigate the risk of life threatening allergic reactions.

Threes staff responders were activated on each emergency call. Two responded to the scene of the incident and the third would source the ambulance from the depot and attend the scene in the vehicle. This helped ensure there were always enough responders on scene to care for the patient and transport them to hospital if required.

Staff assessed patients' conditions and responded by transporting them to what they felt was the most appropriate destination. This mirrored the care provided by local qualified NHS ambulance crews who would transport patients suffering a particular type of heart attack (an ST elevated myocardial infarction) to a cardiac catheter laboratory, patients suffering a stroke to a stroke unit, and those suffering major trauma injuries to a major trauma centre depending upon injuries.

However, this process was undertaken without formal arrangements in place which meant that whilst potentially reducing the risk for patients, other risk factors had not been considered. For example, whilst NHS ambulance staff carry equipment to stabilise patients during longer journeys (for example equipment to stem bleeding or intravenous drugs to help restart the heart), staff did not.

Following our inspection, the service produced a written set of pathways to try to formalise these arrangements. However, we remained concerned because the pathways did not contain enough detail to adequately manage the risks for patients. For example, the pathway relating to cardiac chest pain made no reference to patients with implanted defibrillators or pacemakers or any recommendations to patients presenting with very low heart rates.

The service did not need to have plans in place for catastrophic events such as pandemics or major incidents, because they were not a designated major incident response service nor were they a designated 'first line' response service.

Staffing

All the staff working for the organisation did so on a voluntary basis. There were enough staff with skills and training to provide care and treatment to the local community.

The service had 35 staff responders trained in First Response Emergency Care (FREC). At the time of inspection, two staff were trained to level four and 33 were trained to level three. Several were undertaking level four training at the time of our inspection.

Three staff held the additional role of coordinator. This role was for guidance purposes. For example, coordinators would attend major calls alongside responding members. They had authority to override an operator in dispatching. Pre-alerts referrals and clinical support could also be done through the coordinator. They could be contacted via radio or mobile phone.

Four staff undertook call operator roles, handling emergency or urgent calls made by members of the community requesting assistance, and dispatching staff to respond to patients.

Several staff from the local NHS ambulance trust volunteered their time to provide support, particularly two staff who provided regular governance support.

Emergency and urgent care services

No members had left the service within the last 12 months. Sickness rates were not provided by the service because these were not monitored. This was because staff were not paid employees, and therefore did not respond until they were fit and well again.

Records

The service kept appropriate records of patients' care and treatment. Records were clear, up to date and available to the staff providing care.

Patient records were stored securely when not in use and we saw evidence of this during our inspection.

We reviewed 25 patients' records during our inspection. Each one was dated with times and identifiable incident numbers noted on each record. The records were legible, with call signs recorded so that staff could be traced to individual incidents.

Records contained carbon copies so that one could be left with the patient or hospital.

Audits were completed monthly to help make sure standards were maintained. We reviewed the audit completed in April which showed compliance was 90%.

Staff were encouraged to complete records correctly. We saw evidence of this in the induction pack.

Medicines

The service used a range of medicines to help care for patients. Controlled drugs (prescription medicines which are controlled under the Misuse of Drugs legislation) were not used by the service.

The medical director prescribed medicines which were obtained by the service from either a wholesale supplier or a local community pharmacy. Medicines were stored in locked cabinets and accessed using keys which were stored securely.

Staff used an up to date policy telling them how to store medicines. For administration, the policy referred the reader to Joint Royal Colleges Ambulance Liaison Committee guidelines. However there were no procedures in place specifically regarding the level of training and competence required by staff responsible for administration or when and how to contact the medical director when a prescription was required. Additionally, we saw no evidence of a medicine formulary detailing which medicines should be stocked.

Staff administered salbutamol (a medicine which opens the airways in the lungs to help rectify breathing difficulties). This is a prescription medicine which means someone with authority to prescribe should give permission for it to be given.

Staff used a medicine called Glucagon for patients with low blood sugar levels. Glucagon should be stored at low temperature (between 2°C and 8°C) for up to 36 months or at room temperature (below 25 °C) for 18 months. Stocks we inspected were being stored at room temperature but we saw no evidence that expiry dates had been recorded by staff. Without a record of the expiry date we could not be assured that staff would know when this medicine had reached expiry and needed to be discarded.

Medicines requiring storage at low temperature were stored in fridges. Other medicines were stored at room temperature. Fridge and room temperatures were checked daily but this did not include the minimum and maximum temperature range within the previous 24-hour period. Monitoring this range helps identify occasions when temperatures have exceeded suitable temperature range.

Medical gases including oxygen and nitrous oxide were available on each ambulance. Supplies were in date and checked weekly. Stocks were stored and replenished from an off-site facility. Storage was appropriate, secure and in line with manufacturers' guidance.

Stocks and expiry dates were reviewed weekly to ensure sufficient supplies were maintained. Transfer from storage areas to vehicles were recorded. Any unwanted medicines were returned to the local pharmacy to help make sure unused medicines were removed.

Local medicines training was provided by the medical director. We checked a sample of eight staff, who had all received training in the last 12 months. Advice and guidance was available from the medical director, the local community pharmacist or a staff member who was also a registered nurse.

A newsletter was produced each month which provided staff with up to date information and guidance, including medicine alerts.

Emergency and urgent care services

Each ambulance kept a small number intravenous fluids and cannulation kits for use by paramedics from the NHS ambulance trust to be used when they board the ambulances to treat patients at the scene.

Are emergency and urgent care services effective?

Requires improvement

Evidence-based care and treatment

Despite having access to national guidance by the Joint Royal Colleges Ambulance Liaison Committee (2016) (accessed via mobile phone application or handbook), European Resuscitation Council and National Institute of Health and Care Excellence, care was not always provided in line with it.

Staff used guidelines as a knowledge base when deciding where to transport patients for specialist treatment depending upon their condition. For some patients this involved transporting them further than the nearest emergency department. For example, patients suffering a particular type of heart attack could be transported for specialist treatment to a cardiac catheter laboratory based on clinical guideline 167 (Myocardial infarction with ST-segment elevation: acute management) by the National Institute of Health and Care Excellence. However, this process was not documented at the time of our inspection.

Other undocumented processes were in place for staff to transport patients to major trauma units, stroke centres and burns units rather than the nearest available emergency department.

Staff told us they depended upon regular meetings and training to ensure they knew where to transport patients and how to care for them correctly.

At the end of our inspection we shared our concerns about the fact that these processes were not formally documented.

Following our inspection, the service produced a set of written clinical pathways which were approved by the committee and medical director. These covered care for patients with burns, cardiac chest pain, major trauma, neurological issues, sepsis, stroke, cardiac arrest and non-emergency issues.

However, the pathways were not detailed enough to provide assurance that national guidance was being robustly followed. For example, the pathway for treating burns did not provide any details about irrigating the wound despite royal college guidance stating chemical burns should be irrigated for a minimum of 15 minutes and other burns for a maximum of 20 minutes.

Despite there being a range of different treatment plans depending upon specific injuries (for example abdominal, head, limb or pelvic trauma) in the guidance there were none in the clinical pathway written by the service.

If salbutamol needed to be administered, staff said they sought authorisation from the medical director before administering this medicine. The service was unable to provide any evidence of a written process and no alternative process for occasions when the medical director could not be contacted. This meant we were not assured staff were always administering this medicine in line with legal requirements.

Pain relief

The service had access to appropriate levels of pain relief. Staff monitored patients' levels of pain and gave pain relief however this was not always documented.

Out of the 25 records we reviewed, 13 required documented pain scores for the patients. However, this was only documented in six of those 13 records we reviewed. The records where pain scores were omitted were for patients suffering burns, abdominal pain and limb or head injuries.

Staff carried a range of pain relief including paracetamol and nitrous oxide (gas which can be inhaled).

Peoples' pain was assessed using pain score charts and pictorial pain score charts for those who found communication more difficult (children, patients living with dementia or patients with a learning disability).

Response times

The service monitored their response times to help make sure they reached people as quickly as practicable.

Calls were graded as red or green. In May 2018 records showed that the average response time for green calls was 5 minutes 36 seconds and the average response time for red calls was four minutes 48 seconds.

The service did not benchmark their response times against any other providers locally or nationally.

The service was not monitoring telephone call response times at the time of our inspection.

Patient outcomes

The service monitored some outcomes and used findings to improve care for patients.

Each month staff reviewed the number of calls taken, how many calls each staff member had responded to, and how many patients had been transported to hospital. The nature of each call, the outcome (advised to see GP, transported to an emergency department, glued laceration etc) and the hospital destination (if applicable) was also recorded. Lastly, patient demographics including age range (adult, child, teenage) and gender were also recorded.

The service did not participate in any national audits of patient outcomes.

Competent staff

The service made sure staff were competent in their roles.

Induction handbooks were available for staff. This provided basic information about the registration of the organisation as a regulated health care provider, confidentiality, record keeping, use of the national early warning score tool, capacity to consent, use of vehicles, incident reporting, emergency services, dress code and religious instruction.

Staff received recognised training in First Response in Emergency Care (FREC). At the time of our inspection, 33 of the 35 staff were trained to level three and two were trained to level four.

The level three syllabus covered topics including, resuscitation, bleeding, burns, minor injuries, poisoning, head, spinal and traumatic injury, bleeding, seizure and environmental exposure.

The level four syllabus covered enhanced topics including electrocardiograph interpretation, managing airway devices and managing cases of actual or suspected sexual assault.

Four staff including a coordinator and a manager confirmed that responders routinely interpreted electrocardiograph readings and made clinical decisions about where to take patients for ongoing care. We identified that they did not always have the training required to make these decisions. For example, staff trained to level three in First Response Emergency Care were not trained to interpret electrocardiograph readings.

Following our inspection, the service informed us that level three trained members would refer readings to a trained member of the service for review prior to making decisions about ongoing care.

Fifteen staff (44%) were trained to drive vehicles under emergency conditions. Only those trained were authorised to drive using blue lights and sirens.

Training sessions were provided in partnership with the local ambulance NHS trust. So far training nights had been held in March 2018 which covered safeguarding, infection prevention and control, risk management, duty of candour and incident reporting. 97% of staff responders attended this session. Another training session focused on governance was planned for November 2018.

Appraisals were carried out by trained members of staff. Between March and July 2018, 30% of staff had an appraisal. Managers had a written plan to complete three appraisals each month until March 2019 which would ensure all staff appraisals would be completed by the end of the financial year.

Multi-disciplinary working

Staff worked with a range of different organisations to benefit patients.

Staff liaised with nursing and medical staff in receiving hospitals when bringing in patients. Hospital staff we spoke to described the services's staff as ‘really good’.

We saw evidence of joint working between staff and the local ambulance service NHS trust. Staff contacted the trust for assistance when called to any patient suffering cardiac arrest. They also liaised with trust staff to report safeguarding concerns and access training.

The service worked with other local organisations to provide effective services to the community. We saw joint work being undertaken with the local fire service to reduce risks. Meetings were being arranged with maternity and emergency departments in the local area to help build a good working relationship.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Emergency and urgent care services

Staff received appropriate training and understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005.

Staff told us consent was usually gained verbally and we saw evidence of this when observing care during our inspection.

We also observed staff correctly assessing patients' capacity during our inspection. In one case we observed them take the time to gently persuade a patient to attend hospital.

Are emergency and urgent care services caring?

Good

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients we spoke to described the service as 'fantastic'. In a patient survey, patients described the service as 'very warm and caring' and 'absolutely incredible'.

We observed staff caring for patients in the community and saw them providing care with compassion, dignity and respect. For example, we saw them taking care to maintain a patient's privacy when using a portable urinal during transportation and cleaned their hands for them with cleansing wipes afterwards.

Staff in receiving hospitals described the service's staff as 'caring' and 'committed'.

Emotional support

Staff provided emotional support to patients to minimise their distress. We saw them spend extra time with patients to ensure they were happy with decisions made about their care. They made sure that relatives were supported during this time by including them in discussions.

For patients approaching the end of their lives staff attended the home to support them and their loved ones. Following death further support was provided in line with cultural traditions. Staff provided a supportive link between loved ones and funeral, hospital or HM Coronial staff to help make sure cultural values were understood. For example, by attending funeral homes and inquests with family members.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We saw evidence of this during our inspection when we visited patients with staff. During patient visits, we saw staff spend time explaining the reasons why patients should attend hospital. They explained the choices and the consequences of not attending hospital, particularly when patients did not wish to go.

Where family members were present we saw they were fully involved and understood the reasons that patients should go with them.

Patients' relatives we spoke to described staff as 'brilliant' saying that that they were 'always given great service' by 'fantastic, incredible, highly efficient' staff.

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

Good

Service delivery to meet the needs of local people

The service provided care that reflected the needs of the local population.

The service was primarily used by the local Jewish community However, staff told us they would treat anybody phoning the service from within the area they covered.

The service had links with the local NHS ambulance service. For example, for unexpected surges in demand, patients were advised to contact 999 where the NHS ambulance service would provide a response. There were no service level agreements or contracts held with organisations locally.

The facilities were appropriate for the services being delivered. Ambulances were appropriately located and

available with a suitable deployment method to meet local needs. Staff used their own vehicles to respond in the first instance with local policy in place to help ensure they were in a suitable condition for responding to peoples' needs.

Meeting people's individual needs

The service took account of peoples' individual needs.

Staff understood the needs of the patients they responded to. For example, we saw them identify and manage patients with mental capacity issues appropriately and compassionately.

For patients whose first language was not English, staff had access to language booklets covering up to 25 languages and many spoke English, Yiddish or Hebrew.

For people who had lost a loved one, staff helped them through the bereavement process. A small number of staff were members of the international Misaskim organisation, offering practical and emotional support based upon Jewish laws and traditions.

One staff member was also involved in an organisation called 'Zaka Identification, Extraction and Rescue – True Kindness'- a Jewish voluntary emergency response team. The organisation assists in emergency response teams internationally particularly in searching for and identifying victims of terrorism and other disasters. This provided a link for this service in the community should they require this highly specialist service.

There was provision to care for and transport bariatric patients if required.

Access and flow

People could access the service when they needed it. Response times were monitored so that the service could ensure care was provided in a timely way.

Although the service was not required to meet any national or local targets they aimed to ensure they responded within the limits set nationally for ambulance service NHS trusts. These were an average of seven minutes for life threatening calls and 18 minutes for non-life-threatening calls.

The service managed this with ease with average response times within five minutes for life threatening and six minutes for non-life-threatening calls (May 2018).

Call times were not monitored. When we asked staff managing the service about this they told us there was less requirement given that they were not a front-line service. Should callers be delayed in receiving a response on the telephone, the service had a system which prompted the caller to dial 999. However, managers told us this had never happened.

Learning from complaints and concerns

The service treated concerns and complaints seriously and had a policy in place for investigating and learning lessons from the results.

The service had an up to date complaints policy which explained that complaints could be made in writing, by email, by telephone or verbally to staff.

The service aimed to acknowledge complaints within five working days and respond fully within 21 working days. There was a process in place to source an independent review via another Hatzola organisation, should a complainant remain dissatisfied following the initial complaint response.

Complaints were a standing agenda item at monthly meetings which ensured they would be discussed should any be received.

The service held a complaints log. However, since registering with the Care Quality Commission in 2017, no complaints had been received.

Are emergency and urgent care services well-led?

Requires improvement

Leadership of service

The service had managers in place to run the service who were supported by advisers from the local NHS ambulance trust.

The service had a committee structure comprising of;

- the registered manager who was in the applicant stage of the process at the time of our inspection. He had a background in property and finance and had significant voluntary experience with the service;
- the nominated individual (a person who is nominated to be legally responsible for the regulated activities that are carried out and for ensuring that the essential

standards of quality and safety are met) who also had several years' service voluntary experience and had a background in training, support services, strategic development and multiagency working;
- the service medical director who was a local community GP;
- a safeguarding and incident reporting lead who was a responder; and
- the call operator lead who had significant experience as an operator.

The service had one director. We asked committee members how they assured themselves of the requirements of the fit and proper persons regulation for directors (this regulation is about ensuring that organisations have individuals who are fit and proper to carry out the role of director). Committee members were unfamiliar with the evidence required and did not have any arrangements in place for how they assured themselves. Instead they told us they were assured solely on the basis that the director was 'well known in the community and [had] been in the organisation for 25 years'.

A few minutes later, committee members reviewed the regulation and produced documents for the inspection team, partly due to having them available as part of registered manager application process. Despite this, we remained concerned about the general lack of awareness of the requirements of this regulation.

Vision and strategy for this service

The service had a vision for what it wanted to achieve and plans to turn it into action, developed with involvement from staff, and the community.

The service vision incorporated an aspiration to be an outstanding ambulance service. The service worked to a set of family rather than organisational values which were displayed in areas where staff worked. These were based around each staff member being compassionate and caring, making sure the service was accessible to all, promoting teamwork, making sure 'everyone counts' and finally, treating everyone with respect and dignity.

The service had a five-year strategy, centred around recruitment, training and education, and building relationships locally, whilst complying with regulatory requirements.

We saw plans being finalised to form a pathway for obtaining senior clinical advice and to expand training and education with the local NHS ambulance trust, and evidence of meetings arranged with several local hospital trusts.

Challenges to achieving the strategy had also been identified which were listed on the risk register.

Culture within the service

The service promoted a positive culture that supported and valued its staff, creating a sense of common purpose based on shared values.

Each staff member we spoke to was extremely proud to be involved with the service. They described the community as extended family and were honoured to be involved in caring for members of the community.

Staff described becoming a member as a commitment to be taken seriously and spoke passionately about their roles within the service.

Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. To ensure this was taken seriously, the service had decided to implement their own Freedom to Speak up Guardian. (A Freedom to Speak Up Guardian acts as an independent and impartial source of advice to staff at any stage of raising a concern'). Between July 2017 and September 2018 one concern had been raised.

Governance

The service used a systematic approach to continually improve the quality of its services. The management committee met monthly and discussed a range of specific agenda items. These included; the risk register, action plans, infection prevention and control updates, medicines management updates, learning from incidents, performance and quality, training, appraisals and any other business.

Since registering last year governance had been the focus for the organisation. However, some elements remained unresolved. For example, even though staff were transporting patients directly to cardiac catheter laboratories, stroke units and major trauma centres no clinical pathways or service level agreements with these locations were in place at the time of our inspection. Shortly after our inspection, pathways were introduced but

these did not adequately incorporate national clinical guidelines or local system requirements. We were not assured that governance arrangements were robust in relation to monitoring systems for medicines. This related to information not being available to evidence dates were adjusted to reflect the method that medicines were stored by. Also, documented pathways for the use of salbutamol were not evident. This was important as the medication is a prescribed medication.

Additionally, despite having informal access to seek senior clinical advice from the local ambulance service NHS trust, no formal process had yet been agreed. When we asked the service about this, managers confirmed that a memorandum of understanding was being finalised.

Management of risk, issues and performance

The service had a system in place for identifying risks and planning to eliminate or reduce them.

The service used a risk register to record known or anticipated risks. At the time of our inspection there were 15 risks listed on the register. They included potential issues such as telephony system failure, funding issues or delays waiting for ambulance service NHS trust assistance.

They were categorised into operational, managerial, capacity, financial or clinical and funding risks. Each was given an initial score and a reviewed score following controls which were described in another column. The registered manager was listed as responsible for all risks.

Risks were reviewed monthly during the governance meeting. A specialist in corporate risk was due to review the risk register over the next few weeks, following the inspection.

Information Management

Staff at all levels had sufficient access to information. Data was gathered monthly before being analysed and discussed at monthly governance meetings. Bi-weekly meetings were held with staff where information was shared. Managers also shared information such as updates to practice via a private social media message board.

There were arrangements to ensure that patient records remained confidential. Policies were in place which reminded staff how to manage and store them both on and off vehicles.

Public and staff engagement

The service engaged with patients and staff to plan and manage services effectively.

Surveys were carried out to capture the views of staff. At the time of our inspection one staff survey had been completed and the results of 22 respondents analysed. The questions covered areas including enjoyment of the role, opportunity to make improvements, feelings about communication, responsibility, feeling valued and supported, health and wellbeing, witnessing errors and near misses, bullying and harassment, training and development.

Overall the results were positive or neutral. For example, most staff said they would recommend the service to others, they enjoyed they role within the community, they had enough equipment to undertake their role and got adequate support from each other. The majority also felt that their role made a difference to patients and were satisfied with the care their provided to their community. Almost half respondents neither agreed nor disagreed that they received clear feedback, were supported during a crisis or felt valued by their line manager.

We saw that managers responded to the survey positively. In the survey feedback they wrote to staff confirming that they would meet as a committee and address the issues raised, commenting specifically on each question. They also asked staff to help them by providing ideas about how they could improve on some of the areas required.

In July 2018 staff started work on a patient survey. By the time of our inspection we saw that survey cards were present on ambulances with a view to capturing 10% of patient views. If required, extra patients were contacted afterwards to reach the required 10%.

Following our inspection, we reviewed data from 19 patient questionnaires. These showed that 100% of patients would recommend the service to friends or family members, felt listened to and respected and that staff took the time to interact with them in a respectful and considerate way.

Innovation, improvement and sustainability

The service had implemented changes over the last 12 months, with several policies written and training sessions delivered. The introduction of safeguarding reporting procedures via the local NHS ambulance trust had also been beneficial in moving the service forward.

Emergency and urgent care services

Sustainability was improving with the introduction of more staff which had increased in recent months to 35.

The service acknowledged that these changes rather than innovation had been the priority.

Outstanding practice and areas for improvement

Outstanding practice

- The service had introduced Freedom to Speak Up Guardians – an NHS initiative to promote having an independent and impartial source of advice for staff to raise a concern

Areas for improvement

Action the hospital MUST take to improve

- The service must ensure they only provide care and treatment in line with the training they have received and within their scope of practice.
- The service must have clinical pathways, including medicines oversight, to keep patients safe, which are in line with national guidance and agreed with local networks.

Action the hospital SHOULD take to improve

- The service should review staff practice in relation to service policy for labelling and removing sharps bins.
- Staff should review practice in relation to completion and recording of pain scores in patients' records.
- The service should ensure that medicines are stored effectively.
- The service should consider introducing a monitoring and assurance process to ensure directors continue to meet the requirements listed under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3).
- The service should review the process for formally obtaining senior level clinical advice, particularly where patients present with conditions outside the volunteer staff scope of practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(b)**