Hatzola Trust

Hatzola Trust

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Hatzola is operated by The Hatzola Trust. The service provides emergency and urgent care ambulance services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17-19 January 2017, along with an unannounced visit to the provider on the 31 January 2017.

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

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

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

Services we do not rate

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

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

- The service did not have suitable systems in place to monitor safety over time, which included learning from incidents. Staff were not aware of actions they should take when a 'reportable patient safety incident' occurred. We found six examples that would have met the provider's policy categorisation as a serious incident but had not been reported. Near misses and serious incidents were not identified and there were no systems in place to review safety outcomes for patients.
- Staff demonstrated some understanding of their responsibility to report safeguarding concerns, however there had been no safeguarding referrals made by the service in 2016.
- There was a delay in the escalation of patients with critical conditions. The service had no escalation policy for patients requiring immediate emergency care for critical conditions. The call handlers always put calls through to members, or called one of the two coordinators. They did not immediately call 999 for any situation and there was no policy for doing so.
- We were not assured that patients were assessed and treated in line with best practice and current national guidance. For example, the service did not have clear pathways for common emergency conditions. Ambulance technicians were sometimes working above their competency level. They were responding to calls that were of a more critical nature and more suited for ambulance paramedics.
- Standard operating procedures for call handling were not clear in defining the prioritising of different calls. For example the policy required call operators to wait a set period of time for code one, two and three calls after requesting an ambulance technician attend. Code one calls were for "immediately life threatening situations". For these, the protocol required the operator to wait three minutes and then contact the coordinator if no units had responded. The coordinator would then decide whether to call the London Ambulance Service for further advice. It was unclear how long this process took in practice and delays can cause serious consequences for patients. For example, cardiac arrest patients have 10% less chance of survival for every minute they don't receive CPR (JRCALC guidance).
- Systems to check clinical outcomes for patients were not in place to enable co-ordinators to be assured that staff were making the right decisions on patients' care. This meant there was no way to monitor and learn from good or poor outcomes.

Summary of findings

- Quality checks on patient care records (PCRs) were not effective to check staff had responded appropriately with the correct treatment. We viewed several PCRs where the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) protocols for treatment had not been followed. Staff told us they followed these protocols.

However, we also found the following areas of good practice:

- Equipment and ambulances were clean and kept in good repair.
- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Staff had access to personal protective equipment when needed.
- Ambulance technicians were administering medication appropriately and medical gases were safely stored.
- Staff understood how to raise concerns and record health and safety incidents, such as equipment damage or failure, or injury to staff.
- Patients were treated with compassion and respect and their privacy was maintained.
- Patient feedback was overwhelmingly positive about the service. Patients commented they could ring the provider at anytime and ask for help or advice.
- The service was planned to meet the immediate urgent and emergency care needs of local people. There was flexibility, choice and continuity of care which was reflected in the types of services we saw.
- There were very few complaints and those we viewed had been handled sensitively and promptly. Learning and improvements were made when people complained about the service they received.

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 a warning notice that affected urgent and emergency services. Details are at the end of this report. We conducted a follow up visit on 20 April 2017 and found that the provider had taken steps to begin to address these issues.

Professor Edward Baker
Deputy 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		We regulate independent ambulance services but we do not currently have a legal duty to rate them. Hatzola is an independent ambulance service and patients range from the critically ill to those with minor injuries. The service is staffed by volunteers from the Jewish community and serves the communities of Stamford hill and the surrounding areas of North London.

Hatzola Trust

Detailed findings

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Detailed findings

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Background to Hatzola Trust

Hatzola is operated by The Hatzola Trust. Hatzola was established in 1980 using an operating model used in similar organisations both in the UK and globally. Hatzola means “rescue” or “relief” in Hebrew. Patients served by Hatzola range from the critically ill to those with minor injuries. This service is staffed by volunteers from the Jewish community and serves the communities of Stamford hill and the surrounding areas of north east London.

Hatzola is a free volunteer ambulance team, responding to medical emergencies and casualty incidents in the community – 24 hours a day, seven days a week – aiming to provide rapid medical treatment.

The service has had a registered manager in post since 2014. At the time of the inspection, a replacement registered manager was in the process of being recruited.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and three specialist advisors with expertise in ambulance services. The inspection team was overseen by David Harris, CQC Inspection Manager.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

During the inspection, we visited the Hatzola base at 1 Rookwood Road, London, N16 6SD. We spoke with 22 staff including emergency technicians, administration staff members, call operators and management. We spoke with two patients and one relative. During our inspection, we reviewed over 69 patient care records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was not meeting all standards of quality and safety it was inspected against.

In the reporting period August 2016 to November 2016 there were 1595 calls received by the provider. Emergency and urgent care patient journeys information was unavailable. 43 ambulance technicians and 13 call operators worked in the service. The accountable officer for controlled drugs (CDs) was the registered manager.

Summary of findings

We always ask the following five questions of each service:

Are services safe?

We do not currently have a legal duty to rate independent ambulance services.

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

- The service did not have suitable systems in place to monitor safety over time, which included learning from incidents. Staff were not aware of actions they should take when a 'reportable patient safety incident' occurred. We found six examples that would have met the provider's policy categorisation as a serious incident but had not been reported. Near misses and serious incidents were not identified and there were no systems in place to review safety outcomes for patients.
- Staff demonstrated some understanding of their responsibility to report safeguarding concerns, however there had been no safeguarding referrals made by the service in 2016.
- There was a delay in the escalation of patients with critical conditions. The service had no escalation policy for patients requiring immediate emergency care for critical conditions. The call handlers always put calls through to members, or called one of the two coordinators. They did not immediately call 999 for any situation and there was no policy for doing so.

However, we also found the following areas of good practice:

Emergency and urgent care services

- Equipment and ambulances were clean and kept in good repair.
- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Staff had access to personal protective equipment when needed.
- Ambulance technicians were administering medication appropriately and medical gases were safely stored.
- Staff understood how to raise concerns and record health and safety incidents, such as equipment damage or failure, or injury to staff.

Are services effective?

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

- We were not assured that patients were assessed and treated in line with best practice and current national guidance. For example, the service did not have clear pathways for common emergency conditions. Ambulance technicians were sometimes working above their competency level. They were responding to calls that were of a more critical nature and more suited for ambulance paramedics.
- Standard operating procedures for call handling were not clear in defining the prioritising of different calls. For example the policy required call operators to wait a set period of time for code one, two and three calls after requesting an ambulance technician attend. Code one calls were for "immediately life threatening situations". For these, the protocol required the operator to wait three minutes and then contact the coordinator if no units had responded. The coordinator would then decide whether to call the local NHS ambulance service for further advice. However, it was unclear how long this process took in practice and delays can cause serious consequences for patients. For example, cardiac arrest patients have 10% less chance of survival for every minute they don't receive CPR (JRCALC guidance).
- Systems to check clinical outcomes for patients were not in place to enable co-ordinators to be assured that staff were making the right decisions on patients' care. This meant there was no way to monitor and learn from good or poor outcomes.
- Quality checks on patient care records (PCRs) were not effective to check staff had responded appropriately with the correct treatment. We viewed several PCRs where the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) protocols for treatment had not been followed. Staff told us they followed these protocols.

However, we also found the following areas of good practice:

- Systems were in place to manage incoming and outgoing information from the service to external health and social care professionals.

Are services caring?

We found the following areas of good practice:

- Patients were treated with compassion and respect and their privacy was maintained.
- Patients were involved in care and treatment decisions and staff were observed speaking with patients with dignity and respect. We observed ambulance technicians in the ambulance and in patient's houses showing a respectful and caring attitude to relatives and carers whilst with the patient.
- The service provided information in a manner which enabled patients to understand the treatment options available to them.
- Patient feedback was overwhelmingly positive about the service. Patients commented they could ring the provider at anytime and ask for help or advice.

Are services responsive?

We found the following areas of good practice:

- The service operated a responsive 'see, hear and treat' service to ensure the best use of resources. Resources were used where they were most needed.
- There was service planning to meet the immediate urgent and emergency care needs of local people. There was flexibility, choice and continuity of care which was reflected in the types of services we saw.
- Patients had access to initial assessment, diagnosis or urgent treatment.

Emergency and urgent care services

- There were very few complaints and those we viewed had been handled sensitively and promptly. Learning and improvements were made when people complained about the service they received.
- Many volunteers worked locally and were easily accessible for the local community. The service was seen as a valued and essential part of the community and all staff told us they were proud to be part of it.

However, we also found the following issues that the service provider needs to improve:

- There were no communication aids or hearing loops within ambulance vehicles. The call operators did not have accessible equipment for patients with hearing difficulties. For example; type talk to enable patients that might be hard of hearing to contact by telephone.

Are services well-led?

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

- Systems to monitor and improve quality and identify risk were not adequate or effective. There was no consistent strategy across the service. For example; individual manager roles and accountabilities within the management of the service were unclear. Most policies identified the co-ordinators as the contact point. The strategy was not underpinned by detailed, realistic objectives and plans.
- Governance systems and quality processes were not effective in monitoring the decision making processes or reviewing quality of outcomes for patients.
- The governance arrangements were not effective. Risks were not always identified and when identified not always managed appropriately, effectively or in a timely manner. For example, managers were aware of staff training concerns as it was on the risk register but were unaware that not all staff were following JRCALC treatment guidance in an acute asthma attack.
- Managers were not identifying areas they needed to improve on or areas of good practice. They were not identifying what competencies were required for staff. There was no clear training plan and quality checking processes were not in place.

However, we also found the following areas of good practice:

- The vision and values of the service were well understood by all staff members.
- The service valued its volunteer ambulance technicians (members) and call operators (dispatchers). Managers explained staff receive a card and gift when they had babies or their children got married. One manager said “we thank the family” as volunteers give up a lot of their time and they would not be able to do that if their families did not support them.
- There were effective day to day working arrangements within the service, with administration staff, call operators and ambulance technicians having identified roles and responsibilities.
- The patient survey carried out between January and December 2016 had a response rate of 34%. Overall 84% of those who responded thought their treatment was excellent, 12% good and 4% fair.

Emergency and urgent care services

Are emergency and urgent care services safe?

Incidents

- There had been no never events reported by the service in the past year. A never event is a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers**.**
- Between January and June 2016 the service reported 8 incidents. There were no records of any reported incidents since that date.
- Staff did not follow provider guidelines for the reporting of serious incidents (SIs) and not all incidents were correctly identified as a serious incident. There had been no SIs identified by the provider. It was unclear whether staff were aware of actions they should take when a 'reportable patient safety incident' occurred. We found six examples that would have met the provider's policy categorisation as a SI. Near misses and SIs were not identified and there were no systems in place to review safety outcomes for patients. Providers are responsible for the safety of their patients, visitors and others using their services, and "must ensure robust systems are in place for recognising, reporting, investigating and responding to serious Incidents and for arranging and resourcing investigations".(NHS England serious incident framework, 2015).
- We saw other examples where the provider did not follow their own guidance in ensuring all staff reported incidents. There were concerns about staff understanding of what should be recorded as an incident and lack of knowledge about when to report. However, staff we spoke with understood how to raise concerns and record health and safety incidents. For example equipment damage or failure, or injury to staff.
- The provider policy definition and list of what constituted a serious incident was not consistent with the NHS England (2015) definition of what constituted a serious incident. NHS England states these can be "isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system". They say "there is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list". The provider policy did not follow this framework in outlining the process and procedures to ensure that serious Incidents were identified correctly, investigated thoroughly and learned from to prevent the likelihood of similar incidents happening again.
- We were not assured managers were aware of their responsibilities under duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were not able to accurately explain what responsibilities they had under duty of candour.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service did not have a clinical quality dashboard. Systems that were in place were not effective monitoring safety. Systems for reviewing patient care records were ineffective and senior managers were not aware that staff were not following the provider's policy as they were not recognising and reporting serious incidents

Cleanliness, infection control and hygiene

- We looked at three ambulances and found equipment was clean and staff complied with the provider's cleaning schedules. An external service was routinely used to deep clean ambulances on a twelve-weekly basis and also when required at other times. We saw cleaning records for the last 12 months that confirmed this.
- There were weekly cleaning checklists which covered all flat surfaces. Chemicals were used to carry out weekly

cleans with disposable mop heads and cleaning materials. Cleaning guides and product information sheets had been supplied and were displayed next to the chemicals which were available for staff to use.

- Hand sanitising gel was available within clinical areas and staff uniforms were visibly clean.
- We observed staff on the ambulance and saw they followed best practice infection control guidance in being bare below the elbow. However, we were given an example where ambulance staff did not follow this guidance when transferring a patient to the hospital. We were told that when challenged by nursing staff they had ignored the request to remove their jackets and follow infection control processes before they went onto the ward.
- Hand-washing facilities and personal protective equipment, such as gloves were available. We observed two staff using personal protective equipment appropriately, which was in line with national guidance: Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE.
- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Sharps containers for the safe disposal of used needles were available in each ambulance and were not overfilled. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Environment and equipment

- The service was compliant with MoT testing and vehicle servicing scheduling.
- Relevant equipment was generally available for both adults and children. For example, suitable sized oxygen masks for adults. However, we observed that suitably sized oxygen masks for baby airway equipment were not always available.
- The service had four ambulances, one of which was out of use for repair at the time of inspection. The three vehicles we inspected were clean, equipment was in date and equipment was within its service schedule timeframe. Ambulance cleaning occurred on a weekly and 12 weekly basis. We saw cleaning audits that confirmed vehicles were regularly cleaned.
- Ambulance defects were logged onto a computer database. These were then assessed and graded to ensure that urgent or high priority defects had urgent attention and that low priority tasks could be allocated with other routine work.
- Consumable items were often packaged in tamper proof containers. Mechanisms were in place to notify ambulance staff (members) of use by dates.
- Members often used their own cars initially to respond to a call and equipment was carried in a response bag. This followed normal practice in comparable ambulance services. Members would receive a text message reminding them when equipment or medication was due to expire. The service kept a data base for all items of consumable items that automatically alerted members when changes were due.
- Equipment was available to ensure that children and babies could be safely carried.

Medicines

- Hatzola's medicine management policy stated that "administration to the patient should be in accordance with a prescription written by an authorised health professional or in accordance with the JRCALC Clinical Practice Guideline. The supply and/or administration of these medicines are restricted to supply against a prescription (written/verbal) or under a Patient Group Direction". The service had patient group directives (PGDs) for administration of routine medicines in place. PGDs allow some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber).
- Medicines were accurately recorded, in-date and securely stored in locked rooms or locked fridges. Fridge temperatures were monitored daily. We checked the drugs register and saw that daily stock checks were recorded and stock levels were correct.
- Medical gases were appropriately ordered and stored safely.
- Arrangements were in place for safe disposal of waste and clinical specimens on the ambulances.

Records

- We looked at 36 patient care records in detail. All 36 were found to be incomplete with important information missing. For example, this included: records of baseline observations and repeat observations and details of patients' medicines. Nine records had no consent recorded.
- We did not see any policy for the creation, storage, security and destruction of medical records.
- Patient care records (PCRs) were scanned into a computer in month order and stored in a file. Administration staff told us paper copies were kept for two months and then shredded.

Safeguarding

- The provider's safeguarding children and vulnerable adults policy stated that all patient facing staff "will receive safeguarding children and adults enhanced training to level two". We saw that safeguarding training was included as part of the mandatory training package and staff told us they knew where to find information should they need to. We saw training records that confirmed ambulance technicians had completed safeguarding adults and safeguarding children training.
- However, we viewed staff training certificates and were unable to determine what level safeguarding adults and children training staff had received as part of their mandatory training. The level of training was not recorded on individual staff training certificates or on training information held by the service. Managers did not know but assumed it was level two, so we were unable to assess if the required competencies had been achieved. We asked the provider to clarify with their training provider, however this information was not provided. It is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding training. Level two training is required as a minimum for all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers.
- Systems were in place to allow frontline staff to report safeguarding incidents.
- The service had not reported and safeguarding incidents to the local authority, or made any internal incident reports relating to safeguarding in 2016. This indicated that staff were not identifying potential safeguarding issues and/or were not reporting them appropriately.
- The service did not have access to the child at risk register. Managers told us should they be called to a birth frontline staff would contact the local NHS ambulance service clinical desk to identify whether there was a protection plan in place for the patient.

Mandatory training

- Several ambulance technicians said they had completed additional driver training. A pass in the C1 driving test training was required for ambulance technicians driving vehicles between 3.5 and 7.5 Tonnes. Completion of the training meant they would be competent to drive the ambulances. There was no mandatory requirement for blue light training in ambulance services. There were plans for ambulance technicians to access the course in the future.
- Most staff had completed their statutory and mandatory training. The service provided regular additional training opportunities and staff were proactive in taking the opportunities offered. All ambulance and call handling staff were volunteers and were enthusiastic and committed to attending training whenever possible. Staff told us they prioritised opportunities to attend training.
- Annual mandatory training covered a comprehensive list of subjects and included: equality and diversity, fire safety, infection prevention and control, moving & handling, resuscitation guidelines 2015, health and safety and risk management. All staff were up to date with their mandatory training.
- New staff attended a mandatory induction week that covered the mandatory training programme including basic life support, information governance, infection control, health and safety, fire safety, safeguarding, equality and diversity and manual handling.

Assessing and responding to patient risk

- The service had no triage system, and no escalation policy for patients requiring immediate emergency care

for critical conditions. The call handlers always put calls through to members, or called one of the two coordinators. They did not immediately call 999 for any situation and there was no policy for doing so.

- The patient care records we saw identified processes for ambulance staff to follow to monitor patients for the early detection of deterioration. However, we saw that these were not always completed.
- The ambulance crew had access to clinical advice and escalation process when required. Members told us they could contact the local NHS ambulance service contact desk for advice whenever they needed.
- Staff gave us examples of how they would deal with disturbed or violent patients. Protocols were in place for escalation if required.

Staffing

- There were 43 volunteer ambulance staff in post with an establishment of 50. Recruitment was ongoing to recruit to vacant posts. Arrangements were in place in the event of staff shortage and there were clear details of the minimum number of staff needed to be on duty in order that it could operate safely.
- Systems were in place to deploy extra staff during periods of high demand, for example, bank holidays and weekends. Of the 43 ambulance staff, (also called members).Five were also governance committee members, and two of those were senior members/ coordinators. Nine of the ambulance clinicians were trainees.
- There were 13 dispatchers (call operators) in post and two vacancies with an establishment of 15. There was one "service unit" staff member, two compliance trainees and four administrative staff.
- The service had systems in place to monitor staffing levels and make changes to the rota to ensure there were sufficient staff on duty. All staff were volunteers and were rostered to work shifts. Additional staff were available when needed and would respond to a call stating they were available.
- There had been no reduction or turnover in the number of staff over the last year. Sickness rates were not monitored as staff were volunteers who provided the help that was needed when it was needed.
- Calls were initially responded to by dispatchers who were all volunteers. They worked a four hourly shift pattern of two or three shifts each a week.

Response to major incidents

- The service did not have a major incident policy. Managers told us that "In the event of a major incident, Hatzola will await instructions from the [local NHS ambulance service] or police".
- The service had access to training for major incidents and could be requested to attend by the local NHS ambulance service and police if needed.
- Business continuity arrangements were in place in the event of a fire or essential services breakdown.
- Hatzola operated two emergency phone numbers which were managed independently, both of which were known to service users. In the event that both numbers were unavailable due to a technical problem, service users would need to call 999 for assistance.
- Call operators used designated telephone lines and handsets. In the event that individual operator's lines or handsets were inoperative, alternative arrangements would be made with other operators and/or co-ordinators. This meant there would always be someone available to take emergency calls.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Evidence-based care and treatment

- It was unclear how the provider ensured staff adhered to local policies and procedures. Several staff we spoke with were unclear how they would know about new policies or changes in policies. Records were not kept that identified staff had read and understood policies that they were required to follow.
- The service did not have appropriate systems in place to monitor whether they were following best practice guidance in for example, resuscitation and cardiac arrest survival rates. These are recognised to reduce

unacceptable or undesirable variations in practice and provide a robust basis for providers to deliver the best care. Tools are designed to assist decision-making and allow patient needs to be considered as part of practice.

- The provider told us they followed the Joint Royal College Ambulance Liaison Committee (JRCALC) guidelines and policies. However, effective systems were not in place to identify whether treatment that was being given was appropriate and met best practice guidance. Patient care records were not routinely audited which meant the provider would not be aware whether staff were providing appropriate clinical treatment when responding to an emergency call. We looked at over 36 patient care records in detail and found that not all staff were following recommended protocols. For example, required dose of oxygen treatment for an asthmatic emergency and protocols for epilepsy treatment.

Assessment and planning of care

- Some pathways for care, including conveyance to the appropriate hospital, 'see and treat' or discharge to an alternative provider were in place.
- Some protocols were in place for people with mental health issues and those with a suspected heart attack or stroke.

Response times and patient outcomes

- Standard operating procedures for call handling were not clear in defining the prioritising of different calls. Protocols for escalation of critically ill patients in use by the provider did not reflect protocols used by other ambulance services. This created a risk that patients might not receive the most timely appropriate care. For example the provider's despatch protocols and processes policy (2016) required call operators to wait a set period of time for code one, two and three calls after requesting an ambulance technician to attend. Code one calls were for "immediately life threatening situations". Operators were required to wait three minutes and then contact the coordinator if no units had responded. The coordinator would then decide whether to call the local NHS ambulance service. However, it was unclear how long this process took in practice and delays can cause serious consequences for patients. For example: cardiac arrest patients have 10% less chance of survival for every minute they don't receive CPR (JRCALC guideline).The co-ordinators told us it was rare for staff not to promptly respond to calls and their response times were monitored.
- All calls to the service were recorded and a monitoring system was in place to sample calls.
- The service did not monitor patient outcomes or participate in any national audits.The service covered a small geographical area of approximately one square mile.Most volunteers worked in the community and could get to an emergency call very quickly.The service was run by and for the local community and they did not monitor their performance against other emergency and urgent care service nationally. The service stated they monitored several areas including patient feedback and the number of complaints.
- The service told us they monitored call response rates times and that the majority of calls were responded to in under five minutes and many within two or three minutes. However we did not see records that confirmed this as these were unavailable.
- The service did not have in place any clinical quality measures and no clinical audits were undertaken.
- Coordinators attended emergency calls to monitor performance of clinicians. This was on an ad -hoc basis and not part of a planned review, and observations were not formally reported.

Competent staff

- To support call handlers learning the service had recently introduced observed sessions where operators would be observed for part of a shift taking calls, this observation then contributed to their appraisal.
- Ninety-seven per cent of ambulance technicians and all 13 call operators had received an appraisal.
- All staff had a comprehensive induction. Staff told us they shadowed senior staff as part of their induction. Ambulance technicians were required to undertake a written competency framework as part of their induction. They were observed in their work by the coordinators and more experienced ambulance staff

before being deemed competent. Several members told us they could take as long as they needed to ensure they felt confident and were always paired with another more experienced member.

- The provider policy stated that in order to act in the role of technician, "a person must have achieved a minimum standard equivalent to institute of health care development (IHCD) ambulance aid course and have successfully completed at least the required 750 hours of supervised clinical practice". Managers told us that ambulance technicians completed the theory but were not required to complete the required 750 hours of supervised practice to work as technician within the organisation. The organisation did not have the clinical expertise within the organisation to enable staff to do this.
- All ambulance staff had completed the first response in emergency care (FREC 3 training) QA Level 3 Certificate. The FREC course teaches lifesaving skills that were suited to security staff, medical response teams, fire and police officers, industrial first aiders, healthcare providers and community responders.< > Ninety-six per cent of management and ambulance technicians and trainees had completed medicine training and medicine administration.
- There were no agreed care pathways with other providers.
- The provider had arrangements in place for escalating issues with the local NHS ambulance service when required.
- The service occasionally assisted other providers such as the local NHS ambulance service and local hospitals and GPs to transport patients when asked. Feedback from the local NHS ambulance service and a local NHS trust was positive.
- The service could refer patients to ParaDoc, a doctor led community care service, aimed at reducing hospital admissions.

Multi-disciplinary working

- We observed ambulance staff verbally handing over patients to hospital staff.
- Ambulance staff referred patients on to other services when needed. For example, GPs
- The provider received calls from local GPs and care home providers to arrange transportation for patients when needed. For example, the service would collect patients on discharge from hospital and return them to their own home or care home.

Access to information

- The ambulance crew had access to accurate and up to date satellite navigation systems however most of the patients they treated were from within the local community and within a one mile square patch of east London.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had completed mandatory training in the Mental Capacity Act including deprivation of liberties (DOLs).
- Staff explained how they made decisions about consent if a patient was unconscious or confused. The patient care record included a section on following the best interest decision making process. Staff told us they completed these if they had any concerns about a patient's ability to consent.
- Where a patient was being detained by police under section 136, the provider would assist them in the transportation of the patient, with police on-board, to a designated facility arranged by the police.
- Patients were supported to make decisions. We observed ambulance technicians asking for patients' verbal consent for all interventions. Staff we spoke with were aware of the importance of obtaining consent from patients who were conscious and able to do so before giving any form of care and treatment to them. They gave us several examples of how they had done this.
- Ambulance technicians who attended a patient with mental health needs completed a risk assessment of the situation. If necessary they could request assistance from the police if a patient was likely to become aggressive or to cause themselves or others harm.

Are emergency and urgent care services caring?

Compassionate care

Emergency and urgent care services

- Throughout our inspection all staff who worked in the service verbally demonstrated caring and empathy to patients. One example we observed was when a patient was distressed and the call operator repeatedly reassured the patient throughout the call and was calm and polite.
- We observed ambulance technicians in the ambulance and in patients' houses showing a respectful and caring attitude to relatives and carers whilst with the patient. Ambulance staff gave us examples where they had supported relatives and carers in the event of a deteriorating patient.
- Prior to our inspection we left CQC 'comment cards' at the location with a sealed 'post box' so that patients could leave their comments about the service. We found that 42 patients had comments and all of them were positive. One person wrote " I cannot thank Hatzola enough for the way they dealt with my daughters emergency they got there in less than 3 minutes and were very professional". Another person said, " I felt my wife's needs were dealt with correctly and with dignity and the service was amazing".
- The provider's patient survey carried out between January and December 2016 had a response rate of 34%. Overall 84% of those who responded thought their treatment was excellent, 12% good and 4% fair.
- We reviewed feedback received from patients received by the provider. Comments included "it's just amazing how caring and selfless all the members are" and patients commenting that the provider was "always…available when we need them".

Understanding and involvement of patients and those close to them

- We observed an ambulance technician attending a patient who had fallen. They carefully explained treatment options and listened attentively to what the patient said and discussed whether the patient needed further treatment at the hospital.
- We observed call operators and ambulance technicians taking time to explain what would happen and asking if a patient understood. Staff were aware of the need to protect patients' confidentiality. Patients were given information about care and treatment in a manner that they were able to understand.
- The provider aimed to send feedback survey to all patients seen by the service. All the feedback we viewed was positive. Patients praised the ambulance technicians and said they were "treated with kindness and respect". Other patients commented on the "excellent service" and "quick response". The service aimed to respond quickly and gave advice if needed.

Emotional support

- We were given examples where ambulance staff offered support during distressing events to relatives and carers. Additional support was available within the community to provide ongoing support if needed.
- The service signposted people to bereavement support services in the local community to support relatives of patients who died before arrival at hospital.
- Patients who were distressed, anxious and/or confused were supported or referred onto relevant local services. For example, we observed two staff members appropriately supporting an anxious patient. The patient was not rushed and they took as long as they needed to gain the confidence of the patient before transporting them to hospital.

Supporting people to manage their own health

- Any patient could ring the providers contact number and ask for help or advice. Staff tried to help with information and advice and were able to signpost or refer onto other services if needed.
- All the staff lived and most worked within the local community. They often knew most elderly patients that had come into contact with the service and could offer support to frequent patients.

Are emergency and urgent care services responsive to people's needs?
(for example, to feedback?)

Service planning and delivery to meet the needs of local people

- The ambulance service was seen as an important community resource and had 43 volunteer ambulance

technicians (members) and 13call operators. All members and staff we spoke with were committed to providing whatever resources, including whatever time was needed, whenever they were needed.

- Many volunteers worked locally and were easily accessible for the local community. The service was seen as a valued and essential part of the community and all staff told us they were proud to be part of it.
- Demand from the local community was increasing with more calls covering a wide range of subjects. For example, signposting people to other services.
  The provider did not have any criteria for its services so responded to all calls.
- Managers had recognised that they needed to increase their pool of trained ambulance volunteers and were actively recruiting from within the Jewish community.
- The service had links with the London NHS Ambulance Trust and good relationships with other emergency services

Meeting people's individual needs

- All vehicles carried water for patient use and unusually for an ambulance service also carried small food packs. This was to ensure that patients and staff could eat if required.
- Staff were asked if there were any aids to communication available if there was a patient who spoke a language other than English, Hebrew or Yiddish. Several staff stated there was nothing available and most of the emergency calls were from the local Jewish community and it had never been a problem.
- Staff gave examples where they had dealt with patients with complex needs. For example patients with a learning disability, dementia and older people with complex needs. However, this was reliant on local in depth community knowledge, and information provided by the patient's family.
- The call operators did not have accessible equipment for patients with hearing difficulties. For example; type talk to enable patients that might be hard of hearing to contact by telephone.

Learning from complaints and concerns

- The service had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and there was a designated responsible person who handled all complaints. The oversight and governance committee reviewed complaints on a monthly basis.
- Complaints posters were displayed in ambulances with contact details and also on the organisation website.
- Managers told us they had few complaints and many complaints were dealt with informally. There were four complaints recorded for 2016. We reviewed the complaints log and found that complaints were investigated and resolved as far as possible to the complainant's satisfaction. All complaints were initially responded to within five working days of receipt. A full response was provided, unless there were exceptional circumstances, within twenty-one working days of receipt.
- Learning points as a result of complaints were discussed at meetings and shared with relevant staff. Staff told us that if the service received a complaint about how they handled a call then the particular call would be listened to by their manager and themselves. Operators were supported and encouraged to reflect on the complaint. When needed support and further learning was provided to support staff. Actions taken in response to complaints were monitored until these were fully resolved.

Are emergency and urgent care services well-led?

The leadership team comprised of the medical director who was a GP, registered manager and non-executive director (NED), two co-ordinators and several ambulance technicians (members) with individual responsibilities for finance, IT and HR as well as other roles within the organisation. .

Vision and strategy for this this core service

- The vision for the service was to "provide a first class emergency response service that meets the needs of patients in the local community". All the staff we spoke with were clear about the vision for the service and proud to do what they could for their local community.

Emergency and urgent care services

- The provider told us there strategy and business plan aimed to: “transform the organisation to deliver a quality service, ensuring that it meets patients changing needs and fully adhered to the regulations governing an emergency service. Develop the capability of the team to meet the needs of patients and meet regulatory requirements and introduce technology to improve the efficiency of the organisation. However we found the strategy was not underpinned by detailed, realistic objectives and plans.
- Systems to monitor and improve quality and identify risk were not effective. There were limited systems to monitor and improve quality and no consistent strategy across the service. For example; individual manager roles and lines of accountabilities within the management of the service were unclear.
- Calls to the service had been increasing and the service had no restriction on what people could contact them about. Managers were aware the lack of criteria for the service meant they received more calls that were not urgent and may be requesting advice. They were considering how they could work more closely with the community and educate them in the prevention of injury to reduce the level of minor injury calls and inform them of where they could go to for help. The service was proud of its community links and did not want to discourage people from ringing.

Governance, risk management and quality measurement

- Governance systems and processes were not effective. There were no effective systems in place for identifying, capturing and managing issues and risk at team and organisation level.
- Individual manager roles and accountabilities within the management were unclear. Systems were not effective in monitoring the decision making processes or reviewing quality of outcomes for patients.
- Managers were not identifying areas the service needed to improve on or areas of good practice. They were not identifying what competencies were required for staff. There was no clear training plan and quality checking processes were not in place.
- The provider had a risk register in place; however, they had not identified all risks found on our inspection. For example; critical clinical risks such as lack of baby airway equipment were not included on risk register with appropriate mitigating actions.
- We reviewed incidents and patient care records over the past year and found a number of concerns. We found the provider was not always following their own incident policy and the NHS England serious incident framework, when reporting on and when categorising what was a serious incident. The service had not notified the CQC of any incidents.
- The provider had a system to ensure that appropriate DBS checks were completed for staff. We saw that all DBS checks had been completed and logged.

Leadership / culture of service related to this core service

- The leadership team comprised of the medical director who was a GP, registered manager and non-executive director (NED), two co-ordinators and several ambulance technicians (members) with individual responsibilities for finance, IT and HR as well as other roles within the organisation. They all met monthly as the operational, oversight and governance committee (OGC) and made decisions for the organisation. The administration manager managed the call operators.
- The leadership and governance structure of the provider was undergoing a transition. For example, new compliance officers and a new registered manager were being recruited. Changes were in the process of being made to the organisational structure, which placed more emphasis on assessing existing performance and potential risks and issues. They were “intending to place a greater focus on learning lessons from the existing activity and identifying opportunities to improve processes and patient services”. However this was not yet in place.
- There were plans to employ a chief operating officer and in the interim, the provider had employed a part-time NED to support the organisation to deliver a transformational change.
- A review had been undertaken of policies and procedures and steps were being taken to improve the level of communication up and down the organisation.

Emergency and urgent care services

- Managers were visible and supportive to staff. The two coordinators and other members on the OGC also worked as ambulance technicians when needed.
- The service relied on its volunteers to run the emergency and urgent care service and acknowledged individual contributions. For example, last July a member had worked as an operator and taken a huge number of calls as they were between jobs. Their contribution had been acknowledged and they had been given a gift receipt for a weekend away at a holiday resort. Staff told us managers were appreciative and recognised the amount of time and commitment volunteers provided. All staff told us they were proud of the service and gave as much time as was needed.
- There were high levels of staff satisfaction and staff said they felt respected, valued supported and appreciated. For example; managers explained staff received a card and gift when they had babies or their children got married. One manager said “we thank the family” as volunteers give up a lot of their time and they would not be able to do that if their families did not support them.

Public and staff engagement

- The provider was well known in the local community and staffed by volunteers from the community.
- The service carried out a patient survey between January and December 2016. The response rate was 34%, with 593 questionnaires sent out and 203 returned. 84% of patients thought their overall treatment was excellent, 12% good and 4% fair. The service introduced the friends and family test questionnaire in December 2016 and had received 15 responses, all saying they were highly likely to recommend the Hatzola ambulance service.
- The service carried out a staff survey, however, this was only for the ambulance staff and not the call handlers. We requested the results of the staff survey but this was not provided.

Innovation, improvement and sustainability

- The service was well funded charity organisation and development plans included moving to a new location.
- The service well supported by the local community and had strong links with local organisations.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that risks to patients are identified, assessed and monitored consistently and ensure policies and processes are implemented and adhered to.
- The provider must ensure that near misses and serious incidents are identified and recorded. They must ensure that guidelines for the reporting of serious incidents are followed and incidents where appropriate are correctly identified as a serious incident. The provider must ensure there are systems in place to review outcomes for patients and that there are systems in place to identify risks and themes.
- The provider must ensure managers are aware of their responsibilities under duty of candour.
- The provider must ensure all staff have completed the required safeguarding adults and safeguarding children's required competency level for their role.
- The provider must ensure that standard operating procedures for call handling and prioritisation do not create a risk that patients might not receive the most timely or appropriate care.
- The provider must take prompt action to address concerns identified during the inspection in relation to the governance of the service. They should ensure they have a clear management structure with clear lines of accountability, and have effective systems to monitor quality and risk.
- The provider must ensure learning from incidents and complaints is used for the purposes of continually evaluating and improving services.
- The provider must ensure the risk register is fit for purpose, identifies all areas of risk and has appropriate action plans in place with identified timescales for completion.

Action the hospital SHOULD take to improve

- The provider should ensure calls to the service are accessible for people with hearing difficulties.
- The provider should ensure all staff (including paid employees and volunteers) are included in the staff survey.

This section is primarily information for the provider

Enforcement actions

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12, section (1)(2)(a)(b)(c)(i), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the provider failed to report all serious incidents. Therefore the provider was not able to assess, monitor or learn from incidents. There was a delay in the escalation of patients with critical conditions. The service had no escalation policy for patients requiring immediate emergency care for critical conditions. We were not assured that patients were assessed and treated in line with best practice and current national guidance. For example, the service did not have clear pathways for common emergency conditions. Ambulance technicians were sometimes working above their competency level. Care and treatment records were incomplete. This meant the provider was not doing everything reasonably possible to mitigate risks because they were not recording essential information for the care and treatment of people using the service. The level of staff training was not recorded within the organisations records or on staff training certificates.

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

This section is primarily information for the provider

Enforcement actions

Regulation 17, (1)(2)(a)(b), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a governance system which included processes and systems to ensure the services operated effectively and in compliance with requirements of relevant regulations. Patient outcomes are not recorded or monitored; therefore quality assurance is not possible. This means that patient outcomes cannot be improved or changed if Hatzola Trust Limited does not have any data from which to work with to improve the quality of services.