Hatzola Trust

Quality Report

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Good**
Are services effective?	**Requires improvement**
Are services caring?	**Not sufficient evidence to rate**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

Hatzola is a charity operated by The Hatzola Trust. The service provides an emergency and urgent care ambulance service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11th February 2020, along with another visit to the provider on the 12th March 2020.

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.

Summary of findings

The service had been inspected previously but not rated. We rated it as **Requires improvement** overall.

- Access to medicines were not always restricted to qualified members of staff.
- Policies were not always written by appropriate people working within the service or signed off at an appropriate level.
- The provider did not always use evidence based best practice to inform policies, improve treatments and keep staff updated.
- The provider did not have processes in place to identify addresses where police assistance may be required or locations from which the service received frequent calls from.
- Staff were not always appraised by managers who had full knowledge of the staff members performance.
- Not all staff were trained in risk identification and management.
- The provider had an over-reliance on external management consultants, therefore, had limited continuity built into the workforce.
- The provider did not always complete full pre-employment checks including gaining references, qualifications and employment history.

However, we found the following areas of good practice:

- The provider ensured everybody had completed mandatory training.
- Ambulance vehicles were supplied with antibacterial hand gel and cleaning equipment, and personal protective equipment (PPE) was available.
- The provider had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Summary of findings

- The provider gained feedback from patients and relatives who praised staff for their compassion and support.
- The provider had strong links to the community served.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

Nigel Acheson

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	Summary of each main service
Emergency and urgent care	**Requires improvement** 	Emergency and urgent care were the only regulated activity. Between March 2019 and February 2020, 8270 calls were received by Hatzola Trust and 4288 of these calls received an ambulance response.

Summary of findings

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Hatzola Trust

Services we looked at

Emergency and Urgent Care

Summary of this inspection

Background to Hatzola Trust

Hatzola is operated by Hatzola Trust. Hatzola was established in 1979 using an operational model used in similar organisations both in the UK and globally. Hatzola means ''rescue'' or ''relief'' in Hebrew. Patients services by Hatzola Trust range from the critically unwell to those with minor injuries.

The service is staffed by volunteers from the Jewish community of Stamford Hill and surrounding areas of north east London.

Hatzola is a volunteer's ambulance service, 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.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC lead inspector and a specialist advisor with expertise in emergency and urgent care. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about Hatzola Trust

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.

During the inspection we visited the operating base. We spoke with 11 staff including, three responders, the registered manager, the clinical lead, medical director and admin staff. We spoke with parents of one patient. During our inspection, we viewed five sets of patient records.

There were no special reviews or investigations of the service ongoing by CQC at any time during the 12 months before this inspection. The service had been inspected before but was not rated under the previous inspection methodology.

Activity (March 2019 to February 2020)

- 8270 calls were received by Hatzola Trust
- 4288 calls received an ambulance response

All staff working for Hatzola Trust were volunteers, none were employed. At the time of inspection there were 24 call taker/dispatchers and 48 responders. The responders were trained to First Response Emergency Care (FREC) level three. The QA Level 3 Certificate in First Response Emergency Care (RQF) is a regulated and nationally recognised qualification specifically designed for those seeking a career in the emergency services, ambulance service, the event and security medical sector or those who work in high risk workplaces.

Track record on safety (January 2019 to December 2019)

- No never events
- Nine clinical incidents
- No serious injuries

Four complaints were received in the same reporting period.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Good	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Overall	Good	Requires improvement	Not rated	Good	Requires improvement	Requires improvement

Requires improvement

Emergency and urgent care

Safe	Good
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Good
Well-led	Requires improvement

Information about the service

The service provided by Hatzola Trust was a volunteer service providing emergency and urgent care. Hatzola Trust is funded by charitable donations from the Jewish community and donations of equipment from benefactors.

Hatzola Trust provides 24 hour 365 days per year medical support. The service primarily serves the Jewish community in the Stamford Hill area of North East London.

Are emergency and urgent care services safe?

Good

We rated safe as **good**.

Mandatory training

The service provided mandatory training in key skills and made sure everyone completed it.

The service provided mandatory training in topics such as infection prevention and control, medicines management, dementia awareness and safeguarding. There were a number of other mandatory training topics staff were required to complete.

The service ensured everybody had completed mandatory training and the registered manager (RM) kept a spreadsheet which included dates of course attendance and when training was next due.

The RM told us that staff who had not completed refresher training would not be allowed to work for Hatzola until they had done so.

New members of staff completed mandatory training as part of their induction. Training was delivered through an online-training system which allowed staff to print a certificate once training had been completed.

Responders were trained to FREC3 (First Response Emergency Care Level 3) which was refreshed every three years. The RM and admin assistance held oversight of when staff training was required.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

We saw evidence the designated safeguarding lead had completed level three adult and children safeguarding training. At time of inspection 37 staff were level three safeguarding trained, with the 10 remaining staff booked on courses within the month. The RM stated they aimed to have every staff member completed this training by the end of 2020.

The safeguarding adults and children policy was last reviewed December 2019 and was approved by an external consultant. There was no evidence of the medical director, safeguarding lead or clinical lead having input or oversight of the quality of the policy.

The safeguarding adults and children policy advised staff to read the policy alongside the Working Together to Safeguard Children 2018 guidance.

Requires improvement

Emergency and urgent care

Staff we spoke with had the skills and knowledge to identify, report and act to safeguard patients. All staff we spoke with were able to talk through the process of reporting a safeguarding concerns as well as tell us what they felt constituted a safeguarding concern.

The November 2019 management oversight and governance meeting agenda reported that there was a need for more staff to be educated around child accidents and safeguarding as two recent PRF's (patient report forms) had stated ''accidents happen''. The RM told us that awareness of child accidents and safeguarding was provided through safeguarding level three training which all staff were expected to complete.

The RM was clear how to raise a safeguarding alert with the local authority and provided examples of when they had done so. The RM maintained a log of all safeguarding concerns raised, most were reported to be low level concerns and appropriate action taken.

The service completed audits of safeguarding concerns which had been raised. Most referrals related to additional support patients may require, for example, with bathing or dressing.

The computer aided dispatch system (CAD), a system used by emergency operations staff to assess and dispatch ambulance crews, linked previous safeguarding concerns that had been raised at an address.

The RM told us all safeguarding concerns raised through the service had call recordings audited and the PRF reviewed to identify any potential concerns. The findings of the reviews were shared with staff to promote learning.

Cleanliness, infection control and hygiene

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

Staff used infection prevention and control measures (IPC) to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean in line with the services IPC policy.

During our inspection we viewed three ambulances which were visibly clean internally and externally. Reusable equipment such as splints and monitors were visibly clean. All trolleys were clean and clean linen was available.

All three vehicles were inspected had enough antibacterial hand gel, cleaning equipment and personal protective equipment (PPE) available.

There was evidence all vehicles had received an appropriate level of cleaning to reduce the risk of cross infection. The RM told us all vehicles were cleaned in between patients by staff, twice a week by an external company and twice a week by staff.

The service had a process for the deep cleaning of vehicles. There was a contract in place for deep cleaning for each vehicle every six weeks and a spreadsheet detailing the date when deep cleans had taken place. The spreadsheet submitted prior to the inspection stated the last deep clean of all ambulances has taken place in December 2019 with the next deep clean due in January 2020. There was no evidence submitted of any deep cleans undertaken prior to December 2019, therefore there was no evidence that deep cleans took place every six weeks. The RM stated in the event a vehicle became contaminated with body fluids, they would use the cleaning facilities at the local base/station.

We saw evidence of a contract in place for the disposal of clinical waste. Clinical waste was stored in a locked area at the provider's base and collected by an external company on a monthly basis.

We saw completed IPC audits which had been conducted on a monthly basis. There was evidence all vehicles were cleaned in line with best practice.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them.

Prior to our inspection we were informed the service had four ambulances, which were parked at the provider's base. During our inspection we saw only three ambulances as we were told the fourth ambulance was currently off the road for repair. Repairs for vehicles were logged through an audit system to ensure themes and common issues were picked up.

We were told the ambulances were restocked from the provider's base. We observed a vehicle checklist was available from the staff room and these were completed daily by staff and returned to the service's office. Checks were regularly recorded to demonstrate the vehicle was fit for purpose.

All ambulances had staff hard hats on board which were used in the event of having to access areas that posed a risk of falling debris injuring them. However, one of the three ambulances we inspected only had one hard hat available which posed a risk in the event of these being required.

All electronic equipment was tested on an annual basis. Equipment was labelled with the date of the last test which ensured it was fit for use. Equipment we checked had been tested and was in date. This including equipment used for ECG recording.

The three ambulances we saw had relevant emergency equipment available for both adults and children, such as defibrillators and airway management equipment.

Medical gases were stored securely on vehicles in a locked cupboard to prevent the risk of injury to staff and patients. Medical gases were also stored appropriately at the provider's base, in a locked cage outside the office on wooden shelves.

Records showed all vehicles used were compliant with Ministry of Transport (MOT) testing and the vehicles were regularly serviced. There were appropriate records of insurance and road tax.

Each vehicle was fitted with a satellite navigation and tracking system. This system could also be used to monitor when the blue lights were activated which indicated a patient was being conveyed to hospital under emergency conditions.

The RM stated at the end of each day a staff member was responsible for restocking the ambulances who was aware what equipment and consumables should be loaded.

The cupboards on the ambulance were labelled with the contents so staff would know where equipment was located. We found the labels corresponded with the cupboard's contents. This ensured staff could find equipment and consumables in a timely manner when needed in an emergency.

There was no bariatric equipment available for patients such as wide doors and the stretchers to accommodate bariatric patients. The RM told us that in the eventuality responders attended to a bariatric patient, they would refer the call to the local NHS ambulance service for transportation.

There were welfare facilities for staff at the ambulance base including a kitchen and toilet.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient. However, staff identified and quickly acted upon patients at risk of deterioration.

The service had no triage system in place but call takers had a set of clinical symptoms which required them to call 999 for an NHS ambulance in addition to dispatching a Hatzola responder.

There was a written escalation procedure to inform staff of the actions they should take if a patient deteriorated during the transfer. The RM told us if this occurred before or during transfer the crew would contact the local NHS ambulance service for advice and support.

The RM stated the service did not have a policy or list of addresses that staff would not attend without Police support or those addresses the service receives frequent calls from. The RM was aware of one address the service received frequent calls from and she stated the service had been informed the local NHS ambulance service would no longer attend this address. However, as the caller lived with their elderly mother the service continued to attend as they were concerned the call could be genuine and support may be required.

We reviewed the deteriorating patient poster which was in each ambulance. The poster directed staff to conduct National Early Warning Scores (NEWS 2) assessments on patients. We saw evidence of completed NEWS2 assessments in all PRF's we reviewed.

We saw that the service had a policy, dated December 2019, for supporting patients who had an active do not attempt cardiopulmonary resuscitation order (DNACPR). All staff we spoke with were knowledgeable about the protocol they needed to follow.

We reviewed the call takers operator form and the patient record forms (PRF) both did not have a patient risk assessment included.

The clinical lead told us staff could contact the local NHS ambulance service contact desk for advice when required.

There was information for responders to follow and action to take in relation to meningitis and sepsis including a sepsis screening tool.

The activation of the local NHS ambulance trust policy dated January 2020 highlighted when staff should contact the NHS ambulance trust to attend calls that required assistance from paramedics with higher skills. For example, call takers and staff responding to calls had a list of conditions such as cardiac arrest and unresponsiveness which advised the caller to dial 999. This approach facilitated the patient receiving timely treatment delivered by staff with the required skills and knowledge.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

All staff were volunteers, these included 24 call handlers who all are remote workers taking calls and despatching from their own home using equipment such as telephone, iPad and screens provided by the provider. The call handlers work on two-hour shifts ensuring the call handler taking over from them has logged on, any calls not completed are handed over to ensure all sections of the CAD are completed before they log off.

The ambulance technicians had all completed a recognised national qualification, 35 were trained to level three and 13 to level four with the clinical lead being a paramedic. The ambulance responders responded to calls and were despatched by the call takers.

All staff files we reviewed included an up to date disclosure barring service (DBS) certificate in their electronic employee file. Staff told us DBS checks were renewed every three years.

Not all trustees met the Fit and Proper Persons (directors) Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, all three trustee employee files included evidence of their identify and right to work had been checked and all included a DBS check, but none included a record of employment history or reference.

The RM told us there was no set establishment for either call taker/dispatchers or responders.

Records

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

During the inspection we reviewed five PRF's. All contained accurate information, clinical observations and assessment, were legible and up to date.

Details of all calls received by the service were logged on an electronic system. This included patient details, summary of their condition, time the call was made, the time the patient was collected, the location they were taken to and any care or support provided on the journey.

The PRF's contained a carbon copy, with the top part being retained by the service for their records and the bottom copy being left with the patient at the hospital for their records. There was a folder on the ambulance for storage of PRF's and a secure box at the base for staff to place their completed PRF's. The RM was responsible for collecting the PRF's which were scanned onto the electronic system. The paper records were shredded after uploading.

Staff told us if an electrocardiogram (ECG) recording had been carried out on the patient a copy of the ECG record would be printed and scanned and uploaded to the patient's CAD record with the patients' notes for completeness.

The RM told us monthly PRF audits were undertaken and themes for improvement identified and reported to the management board and volunteers via a newsletter. We saw evidence of this documented in information sent to us by the RM.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The provider did not use or store any controlled drugs and none of the volunteers were trained or qualified to administer controlled drugs in their current role with Hatzola.

The service had a medicines management policy dated December 2019 approved by the medical director who is responsible for medicines. The policy had guidance on ordering, possession, disposal, record keeping, and security of medicines used by the service.

The RM stated that medicines were requested by the medical director and ordered and dispensed from one local pharmacy. This demonstrated the medical director had oversight of medications being requested by the service.

The RM told us that all members of staff completed mandatory medicines management training annually. Staff files we reviewed did not include evidence this training had been completed however, the training spreadsheet submitted by the RM showed all staff had completed medicines management training.

Medicines were not stored in a designated area but in an office in locked cupboards secured to the wall. The room was not monitored via CCTV. We were told by the member of staff responsible for restocking the medicine bags that there was restricted access to the medicine cupboards. The policy stated access to the locked cabinet was restricted to qualified members of staff only. During our inspection we noted this was not the case and other non-qualified members of staff had access. The keys to the medicine cupboards were stored in a locked cabinet in the office which was accessed by other staff.

Medicines were stored neatly in the cupboards meaning it was easy to find the medicine needed. We completed a spot check of the medicines which showed they were all within date.

There was a fridge for the storage of glucagon in the office which was unlocked but the glucagon was stored in a locked cage. The fridge temperature was monitored via a WIFI device which alarmed if the temperature was outside the agreed range. The audits of fridge temperatures provided by the service demonstrated the fridge temperatures, maximum and minimum temperatures were recorded weekly. We noted that following the fridge temperature being recorded as out of range, staff had reported this as an incident and reduced the expiry date on the glycogen to June 2021. This meant there was assurance that medicines were stored at the appropriate temperature to guarantee product integrity or that action would be taken if the fridge exceeded acceptable temperatures levels.

Medicines taken onto the ambulances were packed into wipeable medicine pouches. There were specific pouches for the ambulance and another for the response cars. All pouches were sealed with a red tag to identify they had been checked and were ready for use. In December 2019 the service had introduced a system to monitor and record the use of medicines. There was paperwork for staff to record medicine usage, which was submitted alongside the PRF providing an audit trail of medicines used.

The responders collected the medicine pouches from the office. We saw the secure storage cabinets on the three vehicles we inspected where medicines were kept on the vehicles. Any medicines administered to patients were recorded on patient report form (PRF).

There was an identified staff member responsible for uploading the information from the medicine administration sheet to a central database which could be used to identify any discrepancies.

The medicine policy stated that weekly audits were undertaken by a designated staff member and monthly audits were completed by the medicine's lead, which was the medical director. We saw evidence of medicine audits being completed on a monthly basis.

The RM told us the service did not hold or administer controlled drugs (CD) therefore the service did not require a home office licence.

During the inspection we saw out of date medicines were stored in a locked cabinet. The RM told us these were transferred to a blue topped bin which was locked and collected by an external company and a record of all out of date medicines recorded on a central database. The RM told us, and the management oversight and governance meeting minutes demonstrated that waste medicines would were collected quarterly with the first collect completed in December 2019.

The RM told us that when Salbutamol, used to improve respiratory function, was administered this was to be

recorded on the PRF which was then returned to the office. The usage would then be audited by the clinical lead and reported in the medicine's assurance report to the monthly management meeting.

Following our inspection, we were provided with audits signed by the clinical lead for the seven administrations of salbutamol between November 2019 and February 2020. It was not clear what standards the administrations were audited against. The audit summary report included patient history, staff member administering the medicine, any noted side effects and therapeutic benefits. No audits were provided for administration of salbutamol prior to November 2019 therefore it was not clear what arrangements were previously in place or if administration was monitored.

Incidents

The service managed patient safety incidents well. However, staff were not always trained to recognise incidents and near misses. The RM investigated incidents and shared lessons learned with the wider service.

The service had an incident policy dated December 2019 which had been approved by a consultant employed by the service. This policy included different types of incidents, how to report an incident and to whom, as well as timescales for reporting and concluding investigations. The policy did not cover serious untoward incidents as this was a separate policy.

We were told by the RM that all incidents were reported using the dedicated incident reporting phone line, via the CAD system or directly to the office. We saw a poster in the staff base reminding staff of this number and those staff we spoke with were aware of how to report an incident.

We were told the majority of incidents reported at the time of inspection related to equipment or ambulance issues. All non-clinical incidents were investigated by the RM and clinical incidents were reported and investigated by the clinical lead.

The summary of incidents submitted prior to our inspection demonstrated that most incidents related to operators or responders. The summary included the actions taken but it was unclear who had drafted the report, the purpose or the committee it was submitted to.

The service had a duty of candour policy dated December 2019 which had been approved by a consultant employed by the service. There was no evidence this had been reviewed and approved by either the medical director, RM or clinical lead.

The duty of candour policy stated all staff would receive information and guidance as part of their induction. During our inspection we found no evidence of the information that had been shared with staff. However, the mandatory training spreadsheet supplied to us post-inspection, showed all staff had attended duty of candour training.

Are emergency and urgent care services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as **requires improvement**.

Evidence-based care and treatment

The service did not always provide care and treatment based upon national best practice guidance.

We were not reasonably assured the service kept up to date with national guidelines and shared information with crew. The RM stated that the service did not routinely review NICE guidance to ensure policies and procedures were up to date and reflected the latest national guidance. However, we noted the service had copies of the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines in ambulances.

All ambulances we inspected included posters advising staff on the identification and treatment of sepsis which were based on national guidance. This facilitated escalation and the timely provision of care and treatment to the patient.

The RM stated that monthly call audits were undertaken to review decisions made and assess if the agreed call handler script had been followed. The results of these were shared with call handlers and reported to the management oversight and governance meeting as part of the services assurance process.

The patient's eligibility for the service was assessed upon receipt of the call and following an assessment by a call taker. This could result in either Hatzola taking the patient to hospital if they were not an emergency or the patient would be taken to hospital by a local NHS ambulance service. Alternatively, the patient would be treated and left at home with appropriate advice.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief advice in a timely way.

Pain scores were recorded on the PRF's we reviewed. Pain scores were taken in form of a number, 0 to 10, with ten being the most severe pain and 0 being no pain at all. The PRF contained a section for a score to be recorded.

Responders could administer pain relief, such as ibuprofen and paracetamol which was contained within the staff's medicine packs. Nitrous oxide, an inhaled pain relief gas, was also available on the ambulances.

Nutrition and Hydration

Staff assessed patients' drink requirements to meet their needs during a journey. The service adjusted for patients' religious, cultural and other needs.

Bottled water was available on all ambulances we inspected. There was no food provided.

All staff we spoke with were sensitive to the cultural and religious food requirements of patients.

Response times

During the period November 2018 to November 2019 the service received 4477 calls of which 1765 of these calls were transported to hospital or a health facility such as hospice. In this period 241 calls were reported to be critical or urgent calls such as cardiac arrest or not breathing/choking/active seizure. From the data submitted it was not clear how many calls were made to 999 for support from the local NHS ambulance service.

The service monitored response times and the time each patient took to complete. We were told by the RM that once the call handler had recorded the patient's details, the location would be broadcast to all volunteers via the radio system and the first two members of staff would attend the patient using their response cars. If an ambulance was required a third member of staff would drive to base to collect an ambulance, then travel to the patient's location.

All staff responding to calls lived locally and could respond quickly to patients when required. There was evidence to support these response times on the CAD system. Monthly audits of response times showed that in November 2019, for life threatening calls, members of staff were on scene within five minutes and for non-life threatening they arrived on average within 9.7 minutes. A review of the data submitted prior to our inspection showed that in the reporting period November 2018 to November 2019 the average response time for life threatening calls was six minutes but in September 2019 the response time was nine minutes. The provider told us that it was normal for some months to be higher and other time for it to be lower.

Staff told us if the service did not despatch responders or had not arrived at the patient's location, they were advised to dial 999. There were no audits of the frequency or reason the call handlers advised the caller to contact 999, therefore we were unable to assess the appropriates of this advice.

Staff told us that for non-life threatening calls, if staff were unable to respond within three minutes, the call taker would return the callers call and advise them either to contact 111 or go to their local emergency department.

Patient outcomes

The service did not always monitor the effectiveness of care and treatment.

Patient outcomes and effectiveness of treatment were not recorded or audited. It was reported by the RM that once the patient was handed over to the hospital the service received limited feedback. With limited feedback provided, the service had no information or data to demonstrate the treatment the service had administered to patients had been effective.

The service was exploring with a local hospital the possibility of receiving patient outcome data for patient's conveyed to the trust to evidence patient's outcomes. It was unclear if the trust had agreed to provide this data or

if these conversations were with a specific consultant who was acting in isolation without an information sharing agreement being agreed and signed by the trust's executive team.

Post inspection, the RM told us there was now an agreed governance structure with the local hospital and a standard meeting agenda. A section of PRF's would be discussed including checking if pre-hospital care had been provided appropriately and if patient information was captured correctly. However, at the time of inspection we did not see evidence of this in place and no subsequent information was provided to evidence these meetings.

Hatzola Trust did not work with other Hatzola's and therefore did not compare patient outcomes to other services. However, the medical director did work between Hatzola Trust and Edgeware Hatzola but did not specifically look at patient outcome measures across bother services.

The provider did not participate in relevant quality improvement initiatives, such as local and national clinical audits and benchmarking. Therefore, it was not aware of how it compared with other similar organisations or where it needed to make improvements.

Competent staff

The service made sure staff were competent for their roles. However, staff were not always appraised by individuals who understood their performance.

Staff records were held electronically and included their application form, a copy of their driving licence including the category of vehicle they were qualified to drive with the vehicle licensing agency (DVLA), and DBS. We reviewed a sample of staff files and found them to contain this information. However, there was no evidence that the annual DVLA checks as stated in the pre-inspection information provided by the service, were completed to ensure all staff remained eligible to drive.

We were told by the RM that all volunteers were expected to complete 15 calls per month to maintain their skills. We were not provided with evidence of the document this expectation was recorded in or evidence of any action that had been taken when a volunteer had failed to complete the required number of calls.

The service's conveyance policy stated as part of their continuing professional development (CPD) all staff responding to calls must, as part of their mandatory training, complete the 'Spotting the Sick Child' course which aims to support health professionals in the assessment of the acutely sick child. None of the staff training files we reviewed included evidence of this training having been completed.

There was a staff induction policy dated December 2019, there was no evidence the RM, clinical lead or medical director had approved this policy to ensure it met the service's needs. This policy detailed the induction process for new staff and sign off arrangements.

A checklist was completed for each member of staff when induction training had been completed. The induction policy stated the completed checklist, signed by the manager and staff member would be saved in their personal file. None of the staff files we reviewed included evidence of this checklist being completed or a copy of the declaration of compliance with the induction procedure.

Not all staff were qualified to drive on blue lights and the service did not currently provide blue light driving training. We were told by the RM there were records held to show drivers who had completed their blue light training. We were told this training would have been completed by one of the two providers previously used by the service. Evidence of this training was held for most of the drivers who had completed this training. There was no refresher training for those who had completed the blue light course and no plans in place to provide this.

We saw evidence of staff appraisals being completed. We were told by the RM discussions with staff about their performance took place annually. From the minutes of the management oversight and governance meeting, we noted that most of these had been completed in November and December 2019, with the majority being completed by external management consultants. It was unclear what, if any, involvement the RM, who was in the service daily and clinical lead had had in these appraisals. Therefore, staff were not having their performance reviewed with the most appropriate person, someone who had first-hand knowledge of their working practices.

One of the high risks on the risk register was lack of supervision for staff to ensure they were competent. We

were told that there were plans to start supervision shifts for all staff, which would include a paramedic observing responders providing clinical care and to provide feedback to the staff delivering this care. However, at the time of inspection this supervision had not commenced, and we were not provided with a date this would commence, despite the mandatory training policy stating ride-outs will occur every month for at least two eight-hour shifts by a registered healthcare professional. Therefore, at the time of our inspection there was a lack of supervision arrangements to ensure the staff were competent for the role they were undertaking, and the service was non-compliant with its training policy.

Multidisciplinary working

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

The service was not commissioned by any NHS provider and did not undertake sub-contracted work for other independent health ambulance services.

The RM told us they had been informed the service had previously met, about two years ago, with the deputy medical director of the local NHS ambulance trust to discuss how they could work together and that another meeting was planned in the near future to set up joint working processes.

Staff we spoke with stated they had direct access to the local NHS ambulance service's clinical desk to obtain advice and support and the number was included in the service's conveyance policy. The NHS trust, when asked about the governance arrangements for this, stated that there was no agreement in place and that the provider's staff called 999 for support. However, the conveyance policy we reviewed during this inspection included the clinical support desk number.

The RM provided examples of joint training with the Police and local NHS ambulance trust to provide a coordinated response to incidents and also to expand the skills of the staff. For example, we were told the ambulance trust had advised the service their staff should attend the ambulance's associate ambulance practitioner (APP) training. The RM told us this provided staff with an ideal learning opportunity to act as first responders and to understand when APP's may need to be called upon.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The RM provided examples of working with local clinical commissioning groups (CCGs) on specific health promotion champions such as the measles vaccine programme to encourage greater uptake in the local community. The service is seen as a trusted organisation in the local community and by adding their logo to the posters it was anticipated more parents would attend the clinics and have their child vaccinated.

The service had also worked with a local authority to promote first aid to staff in local schools. They had been awarded a grant to deliver four training sessions in a 12-month period to local school staff. The sessions were reported to be well attended and had improved the staff's knowledge of first aid.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, there were gaps in the service's systems and processes that supported staff in these decisions.

The Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) was part of the mandatory training which staff were required to complete annually. Staff had access to Mental Capacity Act 2005 and Deprivation of Liberties Safeguards policies dated December 2019. This policy had been approved by an external consultant employed by the service, there was no evidence this had been reviewed and approved by either the medical director or clinical lead.

Discussions with the RM and the members of staff showed they was a good understanding about consent and their responsibilities. The PRF's prompted staff to record that consent had been obtained.

Requires improvement

Emergency and urgent care

The RM told us the service did not transport patients detained under the Mental Health Act 1983 or patients experiencing a mental health crisis. The vehicles we saw did not carry restraints and the provider confirmed restraint was not used.

Are emergency and urgent care services caring?

Not sufficient evidence to rate

We did not rate caring because we only observed one patient being transported during the inspection and therefore, we had insufficient evidence to rate this domain.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. On one patient journey we observed we saw staff treated the child and their mother with care and compassion.

We saw feedback from patients and relatives who praised the staff for their compassion and support.

Staff told us they were often from the same Jewish community and were aware of the cultural and religious needs of patients so ensured that people's privacy and dignity needs were understood and were always respected, including during physical or intimate care and examinations.

Emotional support

We observed staff providing emotional support to a family to minimise distress. Staff understood patients' personal, cultural and religious needs.

The RM was able to provide examples where staff offered support during distressing or upsetting events. Additional support was available within the community if a patient required it.

Understanding and involvement of patients and those close to them

We observed staff communicating well with a patient and their relatives regarding their needs.

Staff told us they supported patients, relatives and carers to make informed choices regarding their care and treatment. Staff were able to clearly explain medical conditions to carers to enable them to have a better understanding.

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

Good

We rated responsive as good.

Service delivery to meet the needs of local people

The service was planned in a way that met the needs of those people who chose to use it the service.

The service was not commissioned by an NHS provider to the local community. It was a volunteer organisation that provided a first aid emergency response and ambulance service in the North-East London area. The service was mostly used by the Jewish community who contacted the service directly.

The service was available 24 hours a day, seven days a week. There was a rota for the call handlers 24 hours a day, seven days a week. Two members of staff responding to calls were rostered to cover the night shifts. While all staff members were on call during the day shift.

The service reflected the needs of the local population and ensured choice and continuity of care. Staff were aware of the cultural needs on the Jewish community.

Many staff worked locally and were easily accessible for the local community. The service was seen as a valued and essential part of the local community and staff told us they were proud to be part of Hatzola.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. The service made reasonable adjustments to help patients access services.

The service did not have a criteria for the types of patients the service was able to support. The RM told us the call handlers used a set script, developed by the clinical lead,

to triage calls. While they would respond to all calls, the call handler had a list of calls such as cardiac arrest, where they would also advise the caller to dial 999 for support.

Most staff spoke English, Yiddish and/or Hebrew, therefore, as these were the languages patients who accessed the service spoke, there was no need to have access to a translation service or language line.

The service often referred to a Jewish domiciliary care agency who were able to provide additional support. Patients appeared more likely to accept assistance through this agency which enabled the patient to remain independent in their own home.

The RM and staff had completed assisting and caring for people with dementia training. This training assisted them to meet the needs of patients living with dementia.

The service did not routinely transfer mental health patients and would only do so if they consented to the transfer and never used restraint. Staff told us that if support was requested for a patient living with a mental health condition, they would contact 999. This approach ensured the patient received timely, appropriate support by staff trained to meet their needs.

We reviewed a conveyance policy which included a flow chart to direct staff to which hospital they should convey patients to. For example, taking stroke patients to a specialist centre that had a stroke unit and could meet the patient's needs. However, if following triage, the staff were unsure which hospital the patient should go to they were directed to call the local ambulance's clinical support desk for advice.

Access and flow

We were told journey times were monitored using the CAD system. There were audits completed to demonstrate patients were not waiting for long periods of times and if they waited longer than three minutes for staff to attend their location, they were advised to call the service back or the call handler would call the patient back.

The service had a business continuity plan dated December 2019. This document had been approved by a consultant employed by the service, however, there was no evidence of which staff had been involved in developing and drafting the document or if it had been approved by either the medical director, clinical lead or RM.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service had a complaints policy and procedure document which was dated December 2019. This document had been approved by a consultant employed by the service and there was no evidence this had been reviewed and approved by either the medical director, clinical lead or RM.

The service aimed to acknowledge all complaints within five working days of receipt. It aimed to provide a full response within twenty-one working days.

We were told the service had received four complaints in the 12-month reporting period, most related to callers being advised to call 999 and therefore there was limited evidence lessons learnt. We reviewed the response to these complaints and noted responses had been given in writing within the twenty-one working day period as outlined in the complaints policy.

The service did not have an arrangement with another provider for an independent review of any complaints received and investigations carried out.

Are emergency and urgent care services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Emergency and urgent care

The RM was in charge of day to day running of the service and they were supported by a medical director, who was a local general practitioner (GP) and the clinical lead, a paramedic both who were available via the telephone for support and advice to staff.

Prior to inspection we had received the organisational chart for this service, and this identified reporting arrangements. The main committee was stated as the governance and management committee.

The process in place for annually checking members of the executive and non-executive team were fit and proper persons was not effective. There was no evidence of managerial supervision and appraisal for the management team and trustees.

We were told by the RM, and the November 2019 management oversight and governance meeting agenda, that two new trustees had been appointed. There were staff files for these individuals which confirmed pre-employment checks had been completed. The RM stated these would be completed once the individuals and the service were happy, they had the skills for the role. This was not in line with the service's recruitment policy.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The service had a three-year quality strategy document dated December 2019, this was aimed at providing high quality care and putting quality at the heart of everything the service did. This document had been approved by a consultant employed by the service and there was no evidence which staff had been involved in developing and drafting the document or if it had been approved by either the medical director, clinical lead or RM.

This was the first quality strategy the service has developed and sets out the priorities for 2020. It was not clear how some of the priorities related to an independent ambulance service as they were more aligned to an NHS trust and did not include how achievements of the priorities in the quality strategy would be monitored.

The service had documented values which were displaced in the service's offices.

Culture

The service had processes and procedures in place to ensure there was an open and honest culture.

The RM understood their responsibility in regard to Duty of Candour. There was evidence the provider promoted a culture of openness and honestly at all levels of the service.

The service had a whistleblowing policy dated December 2019 which had been approved by a consultant employed by the service.

Governance

Leaders did not always operate effective governance processes, throughout the service or with partner organisations.

At our previous inspection the provider was told to make improvements in the governance of services. During this inspection we found that the provider had made some improvements, but the action plan produced to resolve the issues identified at the previous inspection had not been fully completed.

The RM told us there was a monthly operation's meeting attended by call handlers and staff who responded to calls which escalated issues to the management board.

There was a management oversight and governance meeting which had a set agenda of 21 items and was attended by the medical director, RM, three trustees and clinical lead. We were also informed that the two external consultants employed by the service attended along with representatives from the operational committee.

The performance papers presented at the management oversight and governance meeting to demonstrate assurance to the trustees were all prepared by an external consultant with limited input from the service's staff. Therefore, there was limited assurance of the clinical guidance the medical director and clinical lead provided to the service.

The service carried out a range of audits and provided staff with feedback to improve their performance. However, the majority of these were undertaken by external consultants and we were not assured that the service's staff were being trained to undertake these to ensure continuity of the service.

The service had a fit and proper requirement policy dated December 2019 which had been approved by a consultant employed by the service, however, there was no evidence this had been reviewed and approved by the RM or nominated individual. The policy had been amended from an NHS organisation and included roles such as deputy director, which the service did not employ and did not include roles such as trustees that the service did employ. Therefore, we were not assured that the service had systems and processes in place to ensure all directors and trustees had completed the necessary checks and these were reviewed annually.

We were told by the RM that two new trustees had been appointed and this was evident in the November 2019 management oversight and governance meeting agenda. There were staff files for these individuals which confirmed pre-employment checks had been completed.

Most policies had been approved by a consultant employed by the service, and there was no evidence they had been reviewed and approved by the RM or nominated individual, medical director or clinical lead in the majority of cases. Therefore, we were not assured that leaders in the organisation had ownership or were aware of their responsibilities as stated in the policies.

The management oversight and governance meeting agenda also included the minutes of the meeting. These were of a poor quality, lacked timescales for action and were not headed with the locations name. We were also provided with separate minutes.

Management of risks, issues and performance

Leaders and teams did not always use systems to manage performance effectively. However, they did identify and escalate relevant risks and issues and identified actions to reduce their impact.

The service had a risk management policy and risk register. The RM stated that any member of staff could identify a potential risk which was discussed with the RM and at the operations committee. The risks were then escalated to a management oversight and governance meeting before being added to the risk register with an identified owner and timescales for review.

The RM identified one main risk for the service as being non-conveyance of patients. To mitigate this risk, we were told a non—conveyance policy and checklist had been introduced. As this non- conveyance policy had only been approved in January 2020, it was too early to judge if the content was reflected in staff practices. The policy stated all staff received information and guidance about the non- conveyance policy as part of their induction. However, the induction policy and completed induction check lists did not include any evidence that non-conveyance information and guidance had been covered at induction.

The non-conveyance policy we reviewed during inspection provided advice to staff on the management of patients who refused treatment or to be conveyed to hospital, included instructions to contact and the direct numbers of the clinical support desk at the local NHS ambulance trust. These included the non-priority number for patients who were not critically ill but needed advice and transport and a separate priority number, staff were advised to call if the patient required urgent treatment such as a cardiac arrest.

The service had a risk register which included 21 open risks, two rated a red, high risk. All risks had actions to mitigate the risk, an identified risk owner and date of next review.

The service carried out a range of audits to monitor the quality of the service provided and to identify areas for improvements. This included audits of PRF's to ensure a consistent level of clinical information was recorded and information was legible and dated. Post inspection the service told us that staff are carrying out some audits each month, for example, health and safety, infection prevention and control and medicine management.

We were told that risk management training would be provided to all members of staff and would form part of the mandatory training for 2020. At the time of our inspection we did not see evidence in the staff training files we reviewed that this training had been completed and we were not informed when this training would be delivered. Therefore, we were not reasonably assured staff were trained to manage risk effectively.

The business continuity plan stated what action would be taken in the event of call handlers, frontline staff, facilities or equipment not be available.

Information management

Requires improvement

Emergency and urgent care

Patient bookings were taken using a telephone application to log details relating to the patient and time the journey was completed. Details of calls were sent to staff via radio, this included the patient's address and condition.

Following our inspection, we requested the provider's data protection policy, this was not provided but we were provided with the access to records and files policy and safe storage of records and documents policy both dated January 2020. These documents were not version controlled it was unclear if these were new policies or updated versions.

Access to electronically held information such as the telephone triage system and on-line policies were password protected. This meant only authorised members of staff had access to the information.

Call takers were aware of the need for confidentiality and ensured that they are not overheard when handling calls. This importance of information management was covered during staff induction.

Public and staff engagement

Patients 'views were considered to improve the service. All patients who used the service were sent a link to provide feedback on their experience. The RM reviewed this feedback and if the patient or relative rated any question three or below, they investigated this which including contacting the patient for more information and speaking with staff.

Staff's views were sought, and they were engaged in the planning and delivery of the service.

We observed that staff were asked for suggestions about how the service could be improved. We noted there was a staff suggestion box in the staff room. However, we saw no examples of improvements which had been made following staff suggestions.

The service produced a monthly newsletter which covered educational/shared learning topics and important news relating to the local Jewish community.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services.

The RM told us about the financial challenges for a charity organisation and had developed plans which included an identified need to move to another location with more space.

The service was well supported by the local community and volunteers lived within the population the organisation served.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all staff have an awareness of safeguarding concerns in relation to child accidents.
- The provider should ensure they have processes in place to identify addresses which may require police assistance or addresses the service receives frequent calls from.
- The provider should ensure employees have suitable employment history and reference checks carried out.
- The provider should ensure there is restricted access to medicines for qualified members of staff only.
- The provider should ensure policies and procedures are agreed and signed off by appropriate members of staff, including, better oversight of policies from the medical director and clinical lead.
- The providers PRF should contain hospital handover information.
- The provider should ensure latest evidence based best practice guidance and national guidelines are used to inform policies and improve patient care and treatment.
- The provider should audit the frequency or reason call handlers advise patients to dial 999 to assess the appropriateness of this advice.
- The provider should ensure they have measures in place to capture patient outcomes to ensure treatments have been effective.
- The provider should participate in relevant quality improvement initiatives, local and national clinical audits and benchmarking to ensure the service can develop and improve.
- The provider should ensure staff HR files accurately reflect all training and employment records.
- The provider should ensure staff are appraised by individuals who are fully aware of their performance.
- The provider should work to improve relationships with the local NHS ambulance trust.
- The provider should ensure annual checking of the fit and proper persons regulation is effective and managerial supervision is in place.
- The provider should ensure policies and meeting agendas have input from service staff.
- The provider should ensure continuity is built within the service and the reliance on external consultants is minimised.
- The provider should ensure staff are trained in risk identification and management.