Hatzola Edgware

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Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Hatzola Edgware is operated by Hatzola Edgware. The organisation provides emergency and urgent care ambulance services.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 14 November 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?

Services we do not rate

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

We found the following areas of good practice:

- Managers documented and investigated all incidents reported to them.
- We were assured that members (volunteer responders) understood what constituted an incident and how to report it.
- Vehicles and equipment were visibly clean, properly maintained and fit for purpose.
- Safeguarding training was regularly delivered and volunteers demonstrated a good understanding of safeguarding and how to raise concerns.
- Members who attended incidents and dispatchers received induction training appropriate to their roles.
- Clinical protocols were used to ensure standards met national practice guidelines.
- Members and dispatchers understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Staff were caring, considerate and respectful of both patients and family members or carers.
- Hatzola Edgware followed guidance issued by the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- Response to call times was consistently within the provider's target of six minutes.
- There was evidence of good multi-disciplinary team work both within the organisation and with external agencies.
- The provider actively sought feedback about the service from patients, relatives and carers.
- The provider's vision was shared and understood by all those whom we spoke with.
- The trustees and leadership team were visible and approachable.
- Members and dispatchers felt included in decisions made by the registered manager and the board of trustees.
- Risks recorded on the risk register accurately reflected most of our findings during this inspection.
- All volunteers were proud to work for Hatzola Edgware and wanted to make a difference for patients.

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

Summary of findings

- Medical gases were not stored securely in compliance with guidance from the British Compressed Gases Association.
- The provider did not obtain satisfactory references as evidence of appropriate conduct in current or previous employment.
- There was no formal appraisal process at the time of this inspection.
- The 'Annual Performance & Development Review Guidance' which related to a new appraisal system planned for January 2018 did not include dispatchers.
- There was variable compliance with National Clinical Performance Indicators for asthma and single limb fractures
- The carbon copy of the patient record form was not always handed to the healthcare provider when patients were transferred, and members did not routinely make a record on the PRF if the patient or carer declined to accept it.

Amanda Stanford
Deputy Chief Inspector of Hospitals, on behalf od the Chief Inspector of Hospitals

Hatzola Edgware

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Hatzola Edgware

Hatzola Edgware was registered with CQC in August 2016. It is based on a 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 wholly funded by charitable donations from the local community and businesses. It is staffed by volunteers from the Jewish community and serves the community of Edgware in North London.

Hatzola is a free volunteer ambulance service, which responds to medical emergencies and casualty incidents in the community 24 hours a day, seven days a week. It aims to support and promote health and wellbeing for all within the local community. People accessed the service by calling the dedicated telephone number which was advertised in the local Jewish community.

There has been a registered manager (operations manager) in post since 2016. There are currently 15 people who respond to emergency calls and they are referred to as members. The first two members to respond to a call attend in their own cars, and another member is dispatched to take the ambulance when required. There are 12 dispatchers whose responsibility it is to answer calls and pass them to the members. There is a senior clinical team which includes a medical director and a senior medical officer, who also has responsibility for training members. There is an office manager who oversees the dispatcher’s rota, the training matrix and collates statistics related to all patient related activities for presentation to the board of trustees.

Our inspection team

The team that inspected the service comprised two CQC inspectors, and three specialist advisors with expertise in ambulance services and pharmacy.

The inspection team was led by David Harris, CQC Inspection Manager. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

During the inspection, we visited the base from which the service operated. We spoke with 15 volunteers including; members, dispatchers and medical leads. We also spoke with the registered manager and the nominated individual who was a trustee. We spoke with three people who had used the service. We also received one 'tell us about your care' comment card, which a patient had completed before our inspection. During our inspection, we reviewed nine patient record forms (PRFs).

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 meeting all standards of quality and safety it was inspected against.

Activity

- In the reporting period February 2017 to October 2017 there were 158 emergency and urgent care patient journeys undertaken.
- There were 462 telephone calls to the service.

The service did not hold any controlled drugs.

Track record on safety

- No never events
- Three clinical incidents, two no harm, one moderate harm.
- No serious injuries
- No complaints

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Emergency and urgent care services

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Are emergency and urgent care services safe?

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. No never events had been declared within the service in the reporting period September 2016 to October 2017.
- Serious incidents are incidents that require further investigation and reporting. The service reported no serious incidents during the reporting period September 2016 to October 2017.
- The provider maintained an incident log. We saw there were 18 recorded incidents, of which four were still open. Each risk was given a risk rating, with three the highest; there were three risks in this category which related to medicines. Recorded actions taken for each included training for members and an amendment to the medication policy. One reported incident related to an allergic drug reaction. This was subsequently discussed with the medical director and a report was submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card Scheme.
- We were assured from discussions we had that members understood what constituted an incident and how to report it. We also saw evidence of learning from incidents; for example one person described an occasion when they had raised an incident related to medicines. This subsequently formed the basis of a training session and we saw that the medicines administration policy was amended to reflect the learning from this incident.
- In another incident, a member described when they were assisting with a patient and the replacement oxygen cylinder was not turned on. This was quickly spotted and there was no resultant harm. However, this was recorded as an incident and the medicine policy was changed as a result whereby two members should

check that the oxygen cylinder is turned on. A member told us they reported any incident related to what they considered inappropriate moving and handling of a patient.

- We saw that all of the above incidents were recorded on the incident log.
- The duty of candour (DoC) 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.
- People understood the application of duty of candour and the registered manager told us they took responsibility for applying this but there had been no incident to date to which the duty of candour applied.

Cleanliness, infection control and hygiene

- The service had an up-to-date infection prevention and control (IPC) policy and members we spoke with knew where it was stored and how to access it.
- A member was recently appointed as IPC lead. Their responsibilities included ensuring there were sufficient IPC materials in stock and maintaining an overview of the cleanliness of the ambulances and good hygiene practice by all.
- We saw a cleaning roster which showed that the ambulances received a weekly clean in addition to 'between patient' cleans. The provider had a contract with an external cleaning company which carried out a monthly deep clean of the vehicles. They also had a 24 hour callout contract with the same company to support decontamination cleans, following transportation of a patient with an identified infectious disease and serious spillages.
- We inspected the two ambulances used by the service and saw there were no gaps in the weekly cleaning schedules. We found all re-usable equipment, including splints, blood pressure cuffs and slide sheets was visibly clean. However we noticed there was a small tear in the mattress of the trolley which had the potential to increase the risk of a healthcare acquired infection. The registered manager told us this would be addressed as soon as possible.
- Alcohol hand sanitiser was available on the ambulances. Members also had access to wipes to decontaminate their hands. Personal protective clothing was available on the ambulances we inspected. This included disposable gloves and aprons, as well as hard hats, which were recently safety tested, and high visibility jackets. There was also disposable clothing to be used for when a member's clothes came into contact with body fluids. There was a bin in each ambulance for the safe disposal of sharps.
- Consumable equipment was stored at the provider's registered address in a store room. Consumable items and documentation was stored on four racks and included stethoscopes, paediatric probes, thermometers and airways. There were also sticks for testing blood and urine and ice packs in the store. All items we checked were in date and in the original packaging.

Environment and equipment

- The ambulances were located on a newly created open hard standing within a housing estate and were ready for use. Vehicles were charged to ensure that the vehicle medical devices and the vehicle were in a fit state to be used.
- The chargers plugged into a standard switch 13 amp double socket, located within a weatherproof external socket box. We saw that the electrical supply could be isolated by undoing the socket box and turning off the socket.
- We saw an e-mail from an electrician which confirmed that the electrical supply was connected to a residual-current device (RCD). An RCD is a device that instantly breaks an electric circuit to prevent serious harm from an ongoing electric shock.
- There was no plumbed water or hot water supply available where the ambulances were parked. Instead clean water was available in 10 litre bottles. We spoke with members who told us they maintained good hand hygiene by using hand gel, which we saw was readily available.
- We saw that there were three spare defibrillator batteries carried in each vehicle, in one case the battery charger was not receiving a 'live' supply. We were told that the organisation was aware of this minor defect and

it was soon to be rectified; we saw correspondence to this effect. Medical devices were monitored and maintained by two of the members whose responsibility it was to oversee supplies and equipment.

- There were labels which indicated that equipment had been recently safety tested.
- The ambulances had a ready supply of consumable items, oxygen and medicines, all of which were stored safely. There was a member whose responsibility it was to order replacement stock and remind others to check their supplies and replace accordingly.
- Waste was managed and disposed of appropriately.
- Both ambulances had equipment which was appropriate for the safe conveyance of children. Securing mechanisms had been provided together with paediatric vacuum mattresses. There were no special arrangements for the conveyance of bariatric patients.
- Members used their own cars to respond to a call but never used them to convey patients (they used the ambulances to convey patients). We saw documentation which confirmed that their cars were regularly serviced and where relevant, had up to date MOT certificates. In addition, there was confirmation from an insurance company that since the responders used their cars in a voluntary capacity and did not get paid mileage, their own car insurance was sufficient cover.
- We saw up to date MOT certificates for the two ambulances with evidence of regular MOTs, and no issues were detected.

Medicines

- Medical gas cylinders were stored in a wire cage on the hard standing where the ambulances were located. The storage of these did not comply with the guidance from the British Compressed Gases Association. Entonox and oxygen were in the cage which was padlocked and sitting on a wooden pallet on the drive way visible to passers-by. Empty and out of date cylinders were clearly marked with a blue tag.
- The wire cage was locked and secured to a pallet. However, whilst this arrangement made it difficult for the oxygen to be stolen, it was possible to move the whole structure if this was the intention.
- There was a wooden pallet stored in the same cage as the oxygen cylinders. Since oxygen strongly supports combustion, the storage of flammable materials with oxygen cylinders is advised against.
- The Hatzola Edgware medicines management policy stated that 'All medical gases stored by Hatzola must be held in secure, locked cabinets specifically designed and approved to hold medical gases'; the store did not meet the requirements of their own policy.
- We drew this to the immediate attention of the registered manager. On the second day of our inspection, we saw an e-mail which confirmed that a new storage facility for the gases was purchased from an industrial gas supply company.
- Hatzola Edgware had a medicines management policy which covered all aspects of medicines used within the service. It included an approved list of medicines and medical gases to be used in the service. It also contained an extensive list of possible medicines that could be used but non registered members working in the service currently only used a limited list of these medicines including oxygen and Entonox.
- To support the administration of these medicines Hatzola had its own in house guidelines for each medicine that members used. We saw that members had received in house training in the use of these medicines.
- The doctors in the service supported the other members with clinical and medicines related queries. They used a wider range of medicines in accordance with their professional registration which they provided themselves.
- We reviewed 15 patient records related to the administration of medicines. These were all complete, recorded contemporaneously and included the patient's allergy status and list of regular medicines documented. When medicines were administered batch numbers and drug ID bag number were recorded to allow traceability.
- We found that the consumable items and drugs were stored appropriately. Sterile items were all in date with intact packaging and in 'as new' condition.

- Oxygen was routinely available on the ambulances and all cylinders we inspected were in date and safely secured.
- Medicines in the ambulances were stored in a grab bag which was secured with a tamper evident seal. Members carried a medicine bag in their cars; they were responsible for ensuring they had sufficient supplies. Medicines bags were tagged to show the earliest expiry date of the contents. Two members were responsible for general supplies and they did quarterly checks of every member's bag. This included the removal and replacement of the advisory defibrillator battery to ensure good battery contact.

Records

- We saw that storage of patient report forms (PRFs) was compliant with the provider's own 'health records policy and procedure (including access to records)'. This stated that 'members must ensure that Health Records are kept secure at all times when being handled and/or transported between locations and externally……and the transportation of patient identifiable paper records, particularly externally, must be kept to a minimum.' There was a locked metal box on the ambulances with a slot in which to drop the PRFs. Members told us when only their car was used; they stored PRFs in the lockable glove box. In all cases, we were told that PRFs were delivered to the office as soon as possible where they were securely stored.
- The provider told us they introduced a PRF audit in June 2017 to support feedback and development. This covered four key areas which included administration, patient information, incident reporting and assessment. The audit showed a compliance rate of between 80% and 100%.
- We reviewed 20 PRFs of which eight still had the patient's own (yellow) section of the PRF. This was not compliant with the provider's own 'health records policy and procedure (including access to records)'. This stated that 'when the patient is not conveyed the second yellow carbon copy of the PRF must be handed to the patient or carer.' The yellow copy is a record of any activity or intervention and in the event of deterioration in the patient after the Hatzola member has left, the yellow sheet would be shown to inform the attending member or NHS paramedic of previous care administered.
- We also noted on one PRF where the complaint was recorded as 'asthma', the patient remained at home but there was no advice documented in the event of a recurrence. On another PRF where an analgesic was administered, there was no second pain score recorded, and where a patient with asthma had difficulty with breathing their PRF did not document their peak flow before and after nebulisation.
- The provider told us that if a patient had a "do not attempt resuscitation" (DNAR) in place they would rely on the family or patient to inform them on their arrival at the scene.

Safeguarding

- We were assured that safeguarding training delivered was aligned with national training modules. The safeguarding training delivered to members met the guidance specified in Safeguarding children and young people: roles and competences for health care staff intercollegiate document Third edition: March 2014.
- Training records confirmed that all members had completed safeguarding training for adults and level 2 safeguarding children training. The safeguarding coordinator had level 3 safeguarding children training and the registered manager was level 4 trained. Members had additional training sessions on female genital mutilation (FGM) and how to recognise signs.
- The provider maintained a safeguarding log on which there were four closed safeguarding concerns. We saw these were explored and acted on accordingly; for example, there was contact with the local authority, police, family or neighbours as appropriate.
- The safeguarding lead had safeguarding responsibilities in their full-time job and applied their skills and knowledge to their safeguarding role with Hatzola. They told us if they had any safeguarding concerns they would discuss these with members of the local multi-agency safeguarding hub.
- Members were able to tell us with confidence of situations where safeguarding concerns were raised. In one example, there was evidence of robust

multidisciplinary collaboration with the local social services and police. This resulted in a robust agreed shared care plan which ensured patient safety as well as relieving pressure on already busy services.

- In another example, the service had frequent calls about a person with repeated falls. This person was referred to their GP and local authority where a care planning meeting was held and appropriate measures taken to ensure the person's safety.
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Schedule 3) specifies the information required in respect of persons employed or appointed for the purposes of a Regulated Activity.
- We looked at a total of 32 recruitment records for all trustees, volunteers and dispatchers and saw each had an application form and an in-date enhanced criminal record check carried out by the Disclosure and Barring Service.
- However, we found that the provider was not compliant with all aspects of this act; in particular, satisfactory evidence of conduct in previous employment and a full employment history, together with a satisfactory written explanation of any gaps in employment. We noted there were no references evident on any of the records we looked at.
- We discussed this with the registered manager. He confirmed that the provider did not take up references. The reason given for this was since all of those involved with Hatzola were from the local Jewish community, 'everyone knew everyone' through the Synagogue, their children's school or as work colleagues. However, he gave CQC assurance that references would be taken up on any future recruits to the service. This included the nine potential recruits who were in the process of being assessed for their suitability to the role of member.

Mandatory training

- The provider maintained a training log which showed that each member was up to date with all mandatory training. Where a member was absent for a training session, we saw they completed this at a later date. The training log was maintained by an administrator and monitored by the senior medical officer (SMO) who was also the main trainer. It was expected that all members attended all training as part of their commitment to their role with Hatzola.
- In the event of a member having a low attendance rate, this was picked up by the registered manager. A coordinator had responsibility for training and in the event of gaps in a member's training; the SMO told us they ensured courses were re-run to capture all members.
- Training sessions were held one evening each week and a register of attendance was kept. Training was delivered by the SMO, who was also a qualified trainer. They were responsible for members on- going continuous professional development. Each non-professionally registered member at Hatzola was trained to First Response Emergency Care (FREC) Level 3 with 7 of the members working towards FREC Level 4.
- Mandatory training included Deprivation of Liberty Safeguards (DOLS) and dementia; Basic Life Support, ECG training, trauma, patient assessment and equipment; airway & respiratory, abdominal pain and acute abdomen, medication and call monitoring.
- We noted that there was no record of training done by dispatchers included in the training log. We were told they were included in training relevant to their role, with a particular focus on the call dispatch pathway. Dispatchers told us they could request training whenever they felt there was a need and this would be provided.

Assessing and responding to patient risk

- Members told us they understood their scope of practice and gave examples of when they escalated to the NHS ambulance service where they had concerns about a patient's condition. They told us where they had any doubt they would immediately request an NHS ambulance.
- They also told us there was constant support available from either the SMO or the two coordinators. They frequently attended call-outs, especially when they were priority calls and were available by telephone at all other times.

Emergency and urgent care services

- The patient report forms we saw identified processes for members to follow to monitor patients for the early detection of deterioration.
- Dispatchers told us their protocol ensured they recognised when to advise a caller to hang up on the call to Hatzola and contact the NHS emergency ambulance service, since a third party cannot make this call. They would still dispatch a member to respond to such calls.
- The provider had access to the local NHS ambulance service's clinical advice line, reserved for emergency services and medical professionals. The coordinators took responsibility for contacting this advice line. They were able to demonstrate to us their knowledge of the most appropriate hospital to convey a patient to in the event of a suspected major trauma or illness, such as a stroke or heart attack. They told us they were able to pre-alert the hospital in order that staff there would be on stand-by to receive the patient.

Staffing

- There were 15 members and 12 dispatchers all of whom were volunteers. The members did not operate on a rota basis and all were available 24 hours a day seven days a week. They told us they fully understood this commitment to the service when they applied to be a member. It was essential that members lived within the catchment area; in certain cases, where the member did not live in the catchment area, their place of work was within it which meant they could respond to day time calls. The manager and coordinators had oversight of which members were unavailable, for example if they were ill or away on holiday.
- The registered manager told us one of the challenges to the service was the ready access to members who could respond to calls during the working day. However, there were currently nine potential new members going through an assessment process which would reduce the concerns related to this.
- There was a rota for the dispatchers, which covered 24 hours a day seven days per week and was organised by an administrator. The administrator told us they never worried about filling all slots on the rota since there was a very high degree of commitment to the service and dispatchers covered for each other and any shortages in the rota whenever this was required.

Anticipated resource and capacity risks:

- The provider anticipated a growth in demand for the service as their reputation spread around the locality. In order to manage this, we saw shortlisted applications from nine potential members who had wished to become members. They were being assessed for their suitability to the role of member at the time of our inspection. This included having a series of meetings with the trustees and established members in order to ensure they fully understood what the commitments and expectations were of the role of a member. Depending on how this screening process went, they would be invited to begin the process of training and induction. One trustee told us the provision of a sufficient number of members to meet demand was always of concern and one which they continued to proactively manage by encouraging applications from the local Jewish community.
- The provider's business continuity plan included ways in which to alert the local community in the event of a systems failure. This was done through a community based charity which would disseminate information through their extensive contacts via email, text messaging and social media. It also took account of situations where the local hospital emergency department was on divert to other hospitals due to capacity. In such circumstances, the coordinator with operational lead on emergency calls would establish the nearest emergency department for the patient to be transferred to.

Response to major incidents

- The registered manager told us Hatzola Edgware had been invited by the Metropolitan Police to participate in a major incident exercise at the beginning of 2017. This was an all-day exercise and involved a number of representatives from Hatzola and the use of their ambulance. They told us there was significant learning from this experience which was later shared with all those who were not in attendance.
- Dispatchers had dedicated telephone landlines and separate handsets; in the event that individual lines or handsets were inoperative, alternative arrangements would be made with dispatchers for them to take any calls. This meant there would always be someone available to take emergency calls.

Emergency and urgent care services

- Hatzola Edgware had a business continuity plan, the purpose of which was to ensure that processes could continue during a time of emergency or disaster. Guidance was included on actions to take in the event of loss of personnel, denial of access to normal place of work, communications or equipment failure and loss of suppliers internal and external to the organisation.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Care and treatment for patients was planned taking account of current evidence based guidance, standards and best practice. Clinical and medical protocols were used to ensure standards met national practice guidelines.
- Training and guidelines were based on Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines. Copies of this guideline were also available on ambulances and at the base centre.
- The provider had a comprehensive range of local policies and procedures, which members told us they were familiar with since it was included in their mandatory training.
- The provider audited outcomes according to the National Clinical Performance Indicators for asthma, single limb fracture, febrile convulsion, falls and mental health self-harm. The results were variable for all of these.
- For example, the service responded to four incidents of asthma between February and July 2017; compliance with the care bundle was 100% on two occasions and 60% and 40% for the remaining two. Compliance with the care bundle for 26 incidents of single limb fractures for between January and August 2017 included 100% compliance on two occasions, and between 0% and 75% for the remainder.
- The service responded to 54 calls related to falls. Compliance rates with the care bundle varied between 33% and 83%, and one occasion of 100% compliance. There were 14 responses related to mental health self-harm; compliance varied between 57% and 86%.

Assessment and planning of care

- The provider's policy 'Recognition Of Life Extinct (ROLE) and DNAR policy' stated 'in all patients with cardio-pulmonary arrest, Cardio-Pulmonary Resuscitation (CPR) should always be attempted whenever there is a chance of survival, however remote.' The policy makes clear that CPR should be withheld in cases where members are certain beyond reasonable doubt that valid documentation related to an advance directive or DNACPR order is in place.
- Guidance from members in 'Advice to Members Regarding the Non-treatment or Non-conveyance of Patients' referenced the mental capacity and mental health status of the patient if they refused to be conveyed to hospital.
- The provider had pathways for care, including conveyance to the appropriate hospital, 'see and treat' or discharge to an alternative provider.
- There was no formally written and documented policy in relation to the management of patients presenting with ST-Elevation Myocardial Infarction (STEMI) and cerebrovascular accident (CVA). However, there was a standard operating procedure in place which was approved by the medical director and in line with JRCALC guidelines.
- The provider 'Paediatric Care Policy and Procedure' for paediatric patient care was delivered in accordance with nationally accepted best practice guidelines including JRCALC, NICE and Resus Council UK. It was recognised that since Hatzola did not screen and triage calls over the phone, a clinician tried to attend every paediatric patient call.

Response times and patient outcomes

- All calls to the service were recorded and a monitoring system was in place to review calls.
- The service was run by and for the local community and did not monitor their performance against other emergency and urgent care service nationally. The service did not participate in any national audits but it did monitor patient outcomes for its own information.
- We saw that call response times were monitored and summarised each month. We looked at data between February and October 2017 which was presented as

three different age brackets; child 0-17, adult 18-69 and elderly 70+. The average response time for children was three minutes, with actual call response times varying between two and four minutes. The average response time for adults was four minutes, with actual call response times varying between three and five minutes. The average response time for elderly was seven minutes, with actual call response times varying between three and fifteen minutes.

Competent members

- There was no appraisal system in place for the registered manager. A trustee told us they considered the manager's performance in the light of the overall performance of the service. They acknowledged that this did not fulfil the whole scope of an appraisal as it did not identify areas for development. They assured us that they would initiate an appraisal for the registered manager as soon as possible.
- There was no formal appraisal system in place for members or dispatchers at the time of this inspection. The registered manager told us they previously had quarterly 'light touch' meetings with people to discuss any concerns in relation to their role. We saw there was a recently agreed 'Annual Performance & Development Review Guidance' which the registered manager told us was to be introduced in January 2018.
- We noted that there was no reference made to dispatchers in the 'Annual Performance & Development Review Guidance'; the registered manager confirmed that their role was not considered as part of the appraisal process at the time of our inspection.
- Call dispatchers told us they had recent training which included listening to recorded calls. These were put through a voice changer to protect anonymity and they said it provided a valuable learning experience.
- The provider had recently developed an induction policy for candidates new to the service.
- Other training was offered in addition to the mandatory training. This included neonatal resuscitation and obstetrics training, both of which were offered as a separate stand alone competency and refreshed annually.
- Members told us the senior medical officer (SMO) had good oversight of their training and development needs. They could request any additional training they thought would enhance their ability to perform their role. One told us of their interest in head injury, for example suffered during a sporting event. In response to this, there was a training session with a focus on how to secure the person so that no further injury is caused. They also said the administrator had oversight of completed training and ensured this was kept up to date.
- The registered manager spoke of the importance of keeping up to date on national changes to policies, procedures and clinical practice. They did this by registering with and receiving regular updates from the Medicines and Healthcare products Regulatory Agency (MHRA). This is an executive agency of the Department of Health which is responsible for ensuring that medicines and medical devices work and are acceptably safe.
- Hatzola Edgware was registered with the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) which provides clinical speciality advice to ambulance services within the UK and it publishes regularly updated clinical guidelines.
- There were copies of the JRCALC 2016 UK Ambulance Services Clinical Practice Guidelines and the 2017 Supplementary Guidelines (to be used in conjunction with the 2016 edition) on both ambulances. Members told us they also carried a copy in their cars. They said they frequently referred to the guidance for example to check the correct dosage of analgesia to administer to a patient.

Coordination with other providers

- The provider had access to the local NHS clinical advice line, reserved for emergency services and medical professionals. They used this when they wanted to alert the hospital emergency department that they were conveying a patient with a suspected life threatening condition such as a cardiac arrest or stroke. In this way, there would be an emergency team waiting at the ambulance area to take over the patient's care.
- The registered manager told us they had recently received positive feedback from the hospital on how this warning system was used appropriately.

Emergency and urgent care services

- We received positive feedback from other providers including the NHS ambulance service and an NHS hospital. Staff reported that handovers to ambulance and hospital staff were effective.

Multi-disciplinary working

- It was evident that there was a culture of multi-disciplinary working between dispatchers, members and clinical and medical leads. Those whom we spoke with told us this was a major strength of the organisation, where 'everyone supports everyone in doing the best job." PRFs recorded advice given by the SMO and dispatchers told us how they had reflected on aspects of certain calls with the registered manager.
- We saw evidence of joint planning between the provider, the local authority mental health services and the police with regards to most effective way in which to respond to a persistent caller to the emergency services. We were told that the resultant plan had a beneficial effect on the patient and served to reduce the volume of calls to all these services.

Access to information

- The ambulance crew had access to accurate and up to date satellite navigation systems on the ambulances and in their cars.
- Given the nature of the service, there was no access to centrally held NHS patient information. This meant that they were not aware of any risk assessment, advance care plan or 'do not attempt resuscitation' order.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Members understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. They were able to tell us in detail how they would deal with the more complex situations where they needed to establish capacity and consent. Where they were in any doubt, they told us they had a 'low threshold' for asking for advice from a coordinator or the SMO.
- The provider had a 'non-conveyancing' policy which gave guidance to members on how to respond to a patient who refused to be conveyed to hospital. This included making the patient aware of the potential consequences of not attending hospital and being satisfied that the patient was able to make an informed choice.
- The provider did not convey patients who were subject to the Mental Health Act.
- Members told us guidance on documentation related to DNAR 'do not attempt resuscitation' order was included in the 'Recognition of Life Extinct (ROLE) and DNAR' policy was helpful. They were clear that 'do not resuscitate' did not mean 'do not treat'.

Are emergency and urgent care services caring?

Compassionate care

- There were no calls from patients during this inspection so we were unable to observe how members and dispatchers interacted with patients. However, we listened to nine call recordings in which clear information was gathered from the patient or relative in a calm and supportive way.
- The dispatcher ensured their instructions were understood and what the next step would be; which in most cases was telling them that there was a member on the way.
- Whilst inspecting the ambulances in an outdoor area, three members of the public stopped to tell us of their appreciation of the service. One said, "we love Hatzola; they are quick, they are thorough and they are helpful."
- We noted that when patients were referred to by all volunteers, this was always with respect and understanding of their situation.
- We saw a summary of 29 comments from patients and relatives collected by the provider between July and September. The service was rated either excellent or good in all areas by all patients.
- Comments included "thank you for the amazing service", "we were tremendously impressed at the dedication, warmth and sensitivity of the Hatzola

members" and "I have never been given more help, support kindness and amazing medical care before. Hatzola made the whole experience very positive for my child and myself. Thank you very much."

Understanding and involvement of patients and those close to them

- We listened to recordings of call and could hear that the caller appeared to be in a more calm state than when they first made the call. The dispatcher ensured their instructions were understood and what the next step would be; which in most cases was telling them that there was a member on the way.

Emotional support

- We were given examples where ambulance members offered support during distressing events to relatives and carers. Additional support was available within the community to provide ongoing support if needed. This included making links with the local Synagogues.
- The registered manager told us support was offered to all Hatzola Edgware volunteers where they had experienced a distressing situation. A dispatcher told us they recently had cause to speak with a coordinator following a call which they found unsettling.

Supporting people to manage their own health

- Hatzola Edgware provided a service to a small local community. Members told us they knew most of those who were vulnerable and those who were frequent callers. They told us this enabled them to initiate contact with local services and seek alternative community support as relevant.

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

Service planning and delivery to meet the needs of local people

- Hatzola Edgware was registered with CQC in August 2016. It is funded by the local Orthodox Jewish community it serves and run by volunteers from within the local community.
- The registered manager told us that calls to the service were increasing which meant there was a need to recruit additional volunteers. There were currently nine potential volunteers being assessed for their suitability to the role.
- The service had links with the NHS Ambulance service and developed good relationships with other emergency services, including the police.

Meeting people's individual needs

- Members demonstrated a sound understanding of complex mental health issues during discussions where they told us about some of the more challenging situations they had faced. For example, they recognised that problems reported by a persistent caller to the service were mental rather than physical health based. Contact was made with the local hospital emergency department and police which resulted in a shared approach to this person's care plan.
- Where a patient did not speak English, the members told us they could access an interpreting service. However, there had been no situation where this had to be used. All coordinators are multilingual in English, Yiddish and Hebrew which tended to be the majority of languages spoken by patients.

Access and flow

- The service operated 24 hours a day seven days a week all year around. There was a rota of 12 dispatchers who answered telephone calls and sent members to the caller's address. Dispatchers were expected to follow the call dispatch pathway when they answered the telephone which helped them identify the priority of the call.
- All calls were recorded and listened to the following day by an administrator to ensure the call dispatch pathway was followed. In the event of any omission or deviation from the prescribed questions, the dispatcher was sent a text to draw this to their attention. There was no written record of this process and therefore no way in which to detect recurrent patterns that might need to be addressed. On the second day of our inspection, we were shown an audit sheet which a coordinator told us would be used in any future call monitoring.

Emergency and urgent care services

- The provider maintained a dashboard on which call response times, nature of call, whether conveyed to hospital and patient outcomes were recorded. Dashboard information was presented and reviewed at the quarterly trustee board meetings.
- We spoke with four dispatchers who told us they had equipment specific to their Hatzola role in their home. This included a dedicated telephone landline and a fixed phone, as well as a hand held phone. They also had a digital radio with charging dock and a guide book which included how calls should be answered, telephone numbers of all Hatzola members and other supporting information and policies.
- In situations where the dispatcher confirmed that the patient was not conscious and breathing, the call was categorised as a 'life threatening' call. At this point, the dispatcher advised the caller to hang up and call an NHS ambulance. They then dispatched two members to the address and in most cases; Hatzola Edgware was first on the scene. Members would begin dealing with the emergency including applying life support and hand over as necessary when the NHS ambulance crew arrived.
- Calls other than those which were life threatening were categorised as priority according to criteria. Some of the symptoms which made a call a priority included chest pains, convulsions, severe burns, choking or where the patient was unable to get up and in a public place. Two members were despatched to attend to the patient.
- Where a call was low severity, and it was not possible to send a member within six minutes, the dispatcher contacted the coordinator who assessed the nature of the call. If they were unable to resolve the matter the caller was advised to contact the NHS 111 helpline.
- All incoming calls were recorded with a time stamp as were all radio messages. We listened in to nine recorded calls and found they were escalated appropriately.
- However, we noted a part of the call dispatch pathway was not followed. This states, 'when taking a call (except for immediately life-threatening calls), the dispatcher should advise the caller to ring back into the service if the patient's condition deteriorates in any way prior to the arrival of a member on scene.' We drew this to the attention of the registered manager who told us this would be addressed at a training session in the immediate future.
- We were assured from our discussions with members and dispatchers and our review of patient referral forms that when there was any doubt about the condition of the patient, a call would be escalated to the NHS ambulance service immediately.

Learning from complaints and concerns

- The service had a complaints policy and a system for handling complaints and concerns. The registered manager was the designated responsible person who handled all complaints. The oversight and governance committee reviewed complaints on a quarterly basis.
- The provider maintained a complaints log. We saw there were no formal complaints made to the service in the reporting period September 2016 to October 2017. One patient complained by telephone about their experience of an uncomfortable journey in the ambulance. We saw the complainant was spoken to immediately about this matter.
- We saw laminated feedback forms clearly displayed in the back of each ambulance which described how to make a complaint.

Are emergency and urgent care services well-led?

Leadership / culture of service related to this core service

- There was a board of trustees whose responsibility it was to ensure that the organisation provided safe and adequate care to its users, and to ensure that volunteers were well led. It was also the trustees' responsibility to ensure that adequate money was raised to ensure the long-term financial wellbeing of the organisation.
- The service was led by the operations manager, who was also a trustee and was the registered manager. They were responsible for the day to day running of the

organisation. This included ensuring that the administrative functions were being carried out in a timely manner and that volunteers were adequately equipped to fulfil their duties.

- There were also two coordinators whose responsibilities included safeguarding, training and line management of members. They monitored the overall performance of the organisation and reported to the trustees. Coordinators ensured one of them was available to support members 24 hours a day seven days per week.
- The medical director set out the medical protocols and provided advice to members when necessary. The medical director consulted on appropriate procedures and standards for the organisation. They were not involved in developing policies (this was done by the senior medical officer), but reviewed them and signed them off.
- The training lead (who was also the senior medical officer) was responsible for identifying the training needs of members and planning and organising their training in line with the guidance of the trustees. They were also responsible for facilitating call reviews and identifying any subsequent training requirements of the organisation.
- Those whom we spoke with were very positive about the organisation as a whole and the registered manager and coordinators in particular. They said that they felt able to speak with the manager and raise any concerns that they may have about the service. Members we spoke with also said that when they raised concerns, they felt listened to.
- We were also told that the trustees were supportive; they offered encouragement rather than put pressure on people as they went about their roles.
- There was a passion and sense of pride in how people spoke of Hatzola Edgware and their roles within it. Many said they felt privileged and proud to serve their community in such a way. They also said the organisation was led by "people who know and really care."

Vision and strategy for this this core service

- Hatzola Edgware stated their mission ' is to improve the welfare of the local community, support and promote health and wellbeing for all within the local community regardless of gender, race and/or religion and provide a fast and efficient emergency ambulance and emergency first response service to Edgware and surrounding areas.'
- This vision was one which was shared and understood by all those whom we spoke with.

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

- There were governance systems and processes to identify, capture and manage issues and risk at team and organisational level.
- Individual manager roles and accountabilities within the management were clear to all those whom we spoke with.
- Managers identified areas in which the service needed to improve and also areas of good practice. They were clear about the competencies which volunteers required to fulfil their role and responded to this by providing a robust training programme for members; though there was a less clearly defined training programme for dispatchers.
- The provider maintained a risk register which was overseen by the registered manager and reviewed each quarter in the trustee governance meeting. We saw this was a standing item on the meeting agenda.
- We saw that those risks accurately reflected most of our findings during this inspection, including omissions on the patient reporting forms (PRF) and inconsistent auditing of PRFs.
- However, there was no reference made to the inconsistent results of the National Clinical Performance Indicators audit. Compliance with the care bundles for asthma, single limb fractures and falls were variable and in some cases were between 60% and 75%.

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

- The nominated individual for the service was also one of the trustees. They told us one of their responsibilities was to ensure the financial security of the service since it was 100% dependent on contributions from within the local Jewish community.

- They also played a major role in community liaison to assure the community that Hatzola Edgware abided by Jewish Law. This was of particular relevance over the Sabbath when telephones were used to answer calls and members drove their cars to attend to patients. Orthodox Jewish law suspends certain stringencies on the Sabbath during emergencies.
- Links have also been made with the local authority and Hatzola have recently been invited to quarterly multidisciplinary information sharing meetings.
- Members and dispatchers used mobile phone group chats to keep in touch and offer each other support.

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

- A member of the trustee board told us one of the biggest challenges they faced was ensuring the financial security of the organisation which was wholly reliant on donations.
- There was a need to recruit additional volunteers to be able to meet the growing demands on the service. There were currently nine people going through an assessment programme after which the registered manager and senior medical officer would decide whether they might be suited to the role of member.
- Dispatchers told us one of the challenges they faced was keeping their skills up if they had not received a call for some time. In such cases they said they reviewed the call dispatch pathway, got support from each other and attended regular training sessions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they obtain satisfactory references as evidence of appropriate conduct in current or previous employment.

Action the provider SHOULD take to improve

- The provider should ensure the yellow carbon copy of the patient record form is handed to the healthcare provider if the patient is transferred, or make a record on the PRF if the patient or carer declines to accept it.
- The provider should ensure robust auditing of patient record forms and provide training related to identified needs.
- The provider should consider an appraisal system for dispatchers
- The provider should work to improve National Clinical Performance Indicators.
- The provider should ensure that the risk register accurately reflects all identified risks.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not obtain satisfactory evidence of conduct in previous employment and a full employment history. There were no references on any of the personnel records we looked at.