Hatzola Northwest Trust

Sneath Avenue Office

Quality Report

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Date of inspection visit: 13th to 14th February 2018
Date of publication: 11/05/2018

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

Ratings

Emergency and urgent care services

Summary of findings

Letter from the Chief Inspector of Hospitals

Hatzola Northwest provides emergency and urgent care. We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on the 13th and 14th February 2018.

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

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

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:

- All reported incidents were documented and investigated. We were assured that volunteers understood what constituted an incident and that learning was shared.
- Vehicles were properly maintained, equipped and visibly clean. All were appropriate for use.
- Safeguarding training was delivered regularly and most volunteers demonstrated a good understanding of safeguarding.
- Call handling and response times were consistently within the provider's targets.
- Clinical protocols were used to ensure the provider met national standards. The provider followed guidance from the National Institute for Clinical and Care Excellent and the Joint Royal Colleges Ambulance Liaison Committee.
- There was evidence of good multidisciplinary team working between volunteers of the service and with other agencies and organisations.
- Staff had the correct competencies for their roles.
- We observed compassionate and respectful care. The provider actively sought feedback from patients and those close to them to monitor and improve the service.
- There was a comprehensive risk register which reflected the risks we found on inspection.
- There was a clear governance structure and leaders were visible and approachable.
- Volunteers were proud to work for the service and understood the vision and values.

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

- Ambient room temperatures were not recorded in all areas where medicines were stored. This meant that the service would not know if the temperature had exceeded the maximum or minimum recommended by the manufacturer for the medication to be effective.
- There were no formal meetings and limited appraisals of volunteer dispatchers.
- Calls were not handled in line with the provider's policy in five out of the ten calls we listened to.

Amanda Stanford

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

Summary of findings

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Our judgements about each of the main services

Service	Rating	Why have we given this rating?
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Sneath Avenue Office

Detailed findings

Services we looked at
Emergency and urgent care

Detailed findings

Contents

Background to Sneath Avenue Office

Hatzola Northwest was registered with the CQC in June 2015. 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. The service is wholly funded by charitable donations from the local community and businesses. It is staffed by trained volunteers from the Jewish community and serves the community of Golders Green in North London.

Hatzola North West is a 24/7 community service, operating 365 days a year to provide a swift response to medical emergencies in the immediate area. People accessed the service by calling the dedicated telephone number which was advertised online and to the local Jewish community, the service responded to anyone who called within the postcodes covered. The service response consisted of teams of volunteer responders coordinated via radio by despatchers who handled calls to the service on dedicated mobile phones. Responders would attend the scene in their cars or by ambulance and provide medical assistance or support.

Hatzola Northwest Trust is a registered charity whose objects are the protection and preservation of health and the relief of sickness. Hatzola North West was started in 1982 by a handful of volunteers who realised the need for a neighbourhood swift response to medical emergencies.

The service is registered to provide urgent and emergency care and there has been a registered manager in post since 2016. There are currently 41 responders who are referred to as members and 17 dispatchers who answer calls and pass them to members. Members initially respond in their own cars or one of three ambulances. The service receives calls relating to all medical emergencies and all calls are responded to, more serious cases are also escalated to the local NHS ambulance trust.

There was a governance committee overseeing strategic planning and a management team including a general manager and a clinical lead who was overseen by a medical director. The day to day running of the service was managed by the general manager who oversaw the administrative functions of the organisation, the implementation of the call handling system and managed call takers.

Individual areas of work such as safeguarding, infection prevention and control and health and safety were overseen by allocated leads in these areas.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, a pharmacist and

two specialist advisors with expertise in ambulance services. The inspection team was led by a CQC lead Inspector and overseen by Nicola Wise, Head of Hospital Inspection.

Facts and data about Sneath Avenue Office

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely

During the inspection, we visited the service's main office and the ambulance station. We spoke with thirteen staff including volunteer dispatchers and responders, board members and managers. We spoke with two patients and one relative. We also received 17 'tell us about your care' comment cards, which patients had completed before our inspection. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC.

Activity (February 2017 to January 2018)

- The service responded to 2939 calls

The service did not store or administer controlled drugs.

Track record on safety:

- No Never events
- Eight clinical incidents, no harm specified
- No serious injuries
- No complaints

Emergency and urgent care services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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Are emergency and urgent care services safe?

Incidents

- The service had reported no never events in the reporting period February 2017 to January 2018.Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service reported no serious incidents during the reporting period February 2017 to January 2018. Serious incidents are incidents that require further investigation and reporting.
- The provider maintained an incident log. We saw that there were eight recorded incidents and the log included the details of the incident, date and actions taken. The log did not describe the severity of harm involved or if incidents remained open. Four incidents involved delays in escalating cardiac arrest patients to the London Ambulance Service. In each of these it was identified that the call taker did not follow the prescribed call taking structure. A debrief with staff involved was undertaken and feedback given to the call takers.A new electronic call logging system had been introduced which more clearly guided the call taker through the structure and there had been no similar incidents since this was implemented in November 2017.
- We were assured from conversations with members that they understood what constituted an incident and how to report it. Incidents were reported to managers of the service with standard incident report forms which were kept in responder's bags and on ambulances. There was an incident reporting policy which covered the procedure for reporting all incidents. We were assured that learning from incidents was shared with members at training events and by email.
- 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.

- Members we spoke with understood the application of duty of candour and the registered manager told us they took responsibility for applying it. The registered manager described keeping patients and their families informed following incidents and apologising on behalf of the service where necessary.

Mandatory training

- The provider maintained a training log that showed when statutory and mandatory training and appraisals were due to be renewed. The training log was maintained by the clinical lead who was also the main trainer. Where members or dispatchers had low training and appraisal rates, this would be picked up by the clinical lead and they would be taken off duty until they were up to date.
- Training events were held weekly and were provided mostly by the clinical lead, who was a qualified training provider, and occasionally by external providers. All 41 members were trained to First Response Emergency Care (FREC) Level 3 and 10 members were in the process of training to FREC Level 4.
- Mandatory training included learning disability awareness, mental health training, duty of candour and incident reporting, mental capacity and resuscitation guidelines. Members could request extra training informally and through the staff survey and managers planned to arrange to have this training delivered. Statutory training included safeguarding, moving and handling, fire safety, health and safety, equality and diversity, Prevent and conflict resolution.
- All statutory and mandatory training had at least a 90% attainment rate except for Prevent (63%), mental capacity (75%) and conflict resolution (39%).

Safeguarding

- All staff we spoke with were aware of who the safeguarding lead was and how to raise concerns if they were worried. The safeguarding lead was trained to Safeguarding Level 3 adults and children and had experience in the area from their regular job as a teacher. The provider had raised one safeguarding alert with the local authority within the reporting period.
- Although many staff had a good understanding of safeguarding, we were not assured from our conversations with staff that there was a consistent understanding throughout the organisation. Dispatchers we spoke with informed us that they had not received any safeguarding training although this was contradicted by training records we saw.
- The electronic call handling system included a free text box to describe safeguarding concerns associated with the call which would be referred to the safeguarding lead. The system also highlighted previous calls to the service which allowed members to notice patterns which may indicate safeguarding concerns.
- Training records indicated that all but three members had completed training in safeguarding adults and children Level 2. Members had additional Prevent training which informed them about protecting vulnerable people from the risk of radicalisation.

Cleanliness, infection control and hygiene

- The service had recently implemented a new infection control policy and members we spoke with knew where to find it. The policy included hand decontamination, blood borne viruses, clinical waste management and personal protective equipment and made reference to current legislation and guidance.
- There was an infection prevention and control (IPC) lead responsible for ensuring IPC materials were in stock and that good IPC practice was followed by members. The lead undertook a regular audit as well as spot checks on members whenever they were on a job. The lead had completed nine audits in December 2017 measuring adherence to 10 IPC standards such as hand hygiene, linen use, cleaning and adherence to the sharps policy. The average score was seven out of 10. The audit policy stated that members scoring less than 75% would be referred to the clinical lead for further training. Six of the nine members audited had not met this standard but it was unclear if they had been referred to the clinical lead.
- Ambulances were regularly deep cleaned by an external company and we saw a timetable indicating that all

three ambulances had been deep cleaned at the right time in the reporting period. Staff told us that ambulances would also be deep cleaned as and when necessary. The IPC lead was responsible for monitoring deep cleaning of the ambulances, they reported there were no concerns with the company contracted to do this.

- There was appropriate personal protective equipment such as gloves, masks and aprons in all ambulances for members to wear when treating patients with communicable disease. Hand sanitizer was also available on ambulances and we observed good infection control practice. Members could describe what precautions would be taken for communicable diseases and ambulances would be put out of use and cleaned after these jobs. There were bins in all ambulances for the safe disposal of sharps.
- We saw that trolley mattresses in the ambulances were clean and covers were intact.

Environment and equipment

- All volunteers were equipped with a mobile phone, digital radio and information pack which included information and policies.
- All consumable equipment was stored at the provider's registered address in individual drawers. All items we checked were in date.
- All equipment in ambulance vehicles was in date for servicing and portable appliance testing.
- Volunteers knew how to manage and dispose of waste correctly and there was a sharps bin on each ambulance.
- Ambulances were equipped to convey children and there was paediatric single use medical equipment such as airways. There was carrying equipment for children in all ambulances.
- We saw up to date MOT certificates for the three ambulances and no problems were highlighted. All vehicles were in date for servicing and were insured.
- Some single use equipment on ambulances we inspected was past its use by date as specified by the manufacturer, this included some bandages and gloves.
- Defibrillators on each of the ambulances self-tested daily and showed on an electronic display if there was any fault. Defibrillators were also tested manually by a nominated person on a regular basis. The service kept a log of defibrillator pads which had been allocated to members, the log specific use by dates for each of the pads and highlighted when they were nearing so the pads could be taken out of use.
- The service had recently implemented a new computer aided dispatch system.

Medicines

- The provider ensured that medicines, medical gases and equipment were checked regularly and replenished, in date and readily accessible to staff. Staff had access to the correct medicines disposal facilities in ambulances and their cars. No controlled drugs were stored at this service. Gases were stored away from flammable materials.
- Medicines expiry dates were recorded on an electronic system which flagged up when a medicine was going to expire 28 days in advance. It also flagged up which member of staff the stock had been issued to and sent them an email allowing time for staff to ensure that it was removed from circulation.
- Volunteer responders administered from a limited formulary as outlined in the provider's standard operating procedures for medicines management. Staff kept records of medicines that were administered to patients.
- Although medicines management did not form part of volunteers' mandatory training, they were supported in the administration of medicines with in house training and had access to medicines information sources. In addition, volunteer responders had their competencies assessed by paramedics who also provided regular training updates. We were assured that volunteers administered medications correctly and understood the limitations on what they could administer.
- We saw that ambient room temperatures were not recorded in rooms where medicines were stored. This meant that the provider could not be assured that the ambient temperature had not risen above or fallen below the recommended range within which the medicines would continue to be effective.

- We were told that verbal consent was sought before medicines were given where possible, however this was not documented.
- Standard operating procedures and clinical information flashcards were available to staff and reflected current Joint Royal Colleges Ambulance Liaison Committee guidelines.

Records

- We saw that patient report forms were completed and stored appropriately and in line with the provider's policy. We looked at ten patient report forms (PRFs) and found that all were compliant with best practice.
- The provider had recently undertaken a PRF audit.
- We were assured from our conversations with volunteers that they understood the correct procedures for special notes such as DNACPRs (do not attempt cardiopulmonary resuscitation) orders.

Assessing and responding to patient risk

- Members understood their scope of practice and gave examples of when they would escalate to the NHS ambulance service such as cardiac arrest, mental health patients and those they were not able to convey. If they had any doubt they would seek advice from the NHS ambulance service.
- Responders also told us that support was always available from the clinical lead or from the two paramedic team leaders on staff.
- We observed that responders undertook comprehensive observations of patients and monitored their condition effectively. Call handlers followed a clear protocol for gathering relevant information from callers, the protocol was embedded in the computer aided dispatch system and prompted dispatchers to advise callers to hang up and call 999. Call handlers would also call the NHS ambulance to ensure they were activated if necessary, as well as activating responders.
- We listened to recordings of ten calls to the service.In five of the calls the dispatcher did not ask the caller if the patient was conscious and breathing. This was in contravention to the Hatzola call handling policy and national best practice guidelines.

Staffing

- There were 41 responders and 17 dispatchers, all of whom were volunteers. All volunteers lived locally to the area served by Hatzola. All responders were considered to be on duty during the day if they were in the area.
- There were night time staffing rotas for dispatchers to ensure that one dispatcher was initially responsible for answering calls during the night, a second dispatcher was on duty to answer calls if the first dispatcher did not. If the phone continued to ring, other dispatchers would answer the call.
- Managers we spoke with felt that there were enough responders and dispatchers to cover demand and ensure the service was continually staffed. They described challenges with providing cover during periods such as school holidays but there had been no instances where the service could not be staffed. The service asked responders to inform them when they would not be available so that they could plan staffing levels. If the service found they did not have adequate staffing to respond to calls, they would refer people to the local NHS ambulance service.

Anticipated resource and capacity risks

- The provider anticipated a growth in demand for the service as they became better known in the community. The provider took their ability to meet capacity in to account when considering advertising.
- There was a sufficient number of responders to meet demand on the service. The service did not have a set staffing capacity plan as there had never been a situation where they had insufficient staff to meet capacity.
- The provider's business continuity plan covered action that should be taken in a range of scenarios which would interrupt the provision of the service.

Response to major incidents

- Members of Hatzola Northwest had taken part in a major incident simulation exercise which included the police and the local NHS ambulance service. This was an all-day exercise which planned the response of a range of local emergency services including Hatzola to a major incident in the area.

- Hatzola had a business continuity plan, the purpose of which was to ensure the continued provision of the service in the event of emergencies.

Are emergency and urgent care services effective?

Evidence-based care and treatment

- Care and treatment of patients took account of current evidence based practice and guidelines. This was overseen by the clinical lead who ensured that clinical procedures and protocols met national standards such as the National Institute for Clinical and Care Excellence and the Joint Royal Colleges Ambulance Liaison Committee.
- The provider had a comprehensive range of local policies and procedures available to responders in their information packs. Training and guidelines were based on national guidelines.
- Since the inspection the provider had begun to audit call taking including whether the dispatcher answered correctly, obtained the address and contact details, asked whether the patient was conscious and awake, ascertained the patient details and medical problem and appropriate dispatch of responders and escalation to 999.
- The provider did not audit patient outcomes beyond finding out informally how the patient was afterwards; this was because it was not possible for them to obtain this information due to patient confidentiality. The clinical lead planned to begin auditing against the national clinical performance indicators for a range of conditions such as cardiac arrest and stroke.

Assessment and planning of care

- There were clear standard operating procedures which specified agreed care pathways according to national standards and guidelines. These included conveyance to the appropriate hospital, 'see and treat' or discharge to an alternative provider.
- The protocol for patients with mental health issues, suspected heart attack or stroke was to activate the local NHS ambulance service.
- Hatzola did not assess or triage calls over the phone so responders were always activated to every call where there was a medical concern and there was a list of scenarios where callers would be advised to immediately to call 999 and the call handler would do the same.

Response times and patient outcomes

- All calls to the service were recorded and serious calls were monitored. At the time inspection there was no formal audit of call handling. Audits were undertaken in response to incidents or concerns.
- The service did not participate in any national audits of response times or patient outcomes. Managers we spoke with expressed an interest in comparing data with other local Hatzola providers.
- We saw that call response times were monitored and summarised each month and had been since the new computer aided dispatch system had been implemented in November 2017. The service audited initial response times, dispatch times and the time for an ambulance to arrive on scene and had data for the period since the new computer aided response system was implemented in November 2017. The average dispatch time was 2.67 minutes and there was an initial response within an average of 5.96 minutes, it took an average of 13.9 minutes for an ambulance to arrive and 51.7 minutes to arrive at hospital since the initial call. The average initial response time and arrival at hospital time was within the provider's target.

Competent staff

- All responders had regular one to one meetings which included a test of clinical competencies; these were undertaken by the clinical lead. There was no formal appraisal system for dispatchers, their performance was reviewed when managers of the service listened back to calls if there had been a concern. The clinical lead ensured that responders had the correct competencies to do their roles through regular one to one meetings and reviewed training to ensure it was adequate.
- Additional training was offered beyond the mandatory and statutory training and responders could request the training they would like to have. Responders and dispatchers used mobile telephone messaging groups to give each other advice.

- Responders could access national guidelines and protocols from the UK Resuscitation Council, the National Institute for Health and Care Excellence and the Joint Royal Colleges Ambulance Liaison Committee. Responders carried copies of medical information and clinical protocols in their cars and referred to them regularly when they needed advice.

Coordination with other providers

- The provider had access to the local NHS ambulance service's clinical advice line which was reserved for emergency services and medical professionals. They used this when they needed to alert appropriate specialties at local hospitals that they were bringing in patients with conditions such as heart attack or stroke.
- Staff told us that the organisation was well known in the local community and worked closely with GPs and care homes to coordinate care.
- Some members had created links with other Hatzola services across the country. They had attended a Europe-wide convention.
- The clinical lead received regular feedback from hospitals that Hatzola conveyed to about the quality of handover. They told us that this feedback was usually positive and any negative feedback was shared to improve.

Multi-disciplinary working

- Volunteers and staff who performed different roles in the organisation worked together to provide an effective service for the community. Dispatchers, responders, clinical and operational leaders supported each other and facilitated a reflective working environment.
- The clinical lead gathered feedback informally from their contacts in the local NHS trusts and told us that they received good feedback about handovers between ambulance and hospital staff.

Access to information

- Due to the nature of the service, they did not have access to NHS patient information such as advance care plans or 'do not attempt resuscitation' orders. Responders we spoke with told us they would involve the family or carers of patients in providing relevant information or documentation relating to the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Responders we spoke with understood the relevant legislation and guidance relating to consent including the Mental Capacity Act 2005. They were able to describe scenarios they had dealt with where a patient did not have capacity and the correct processes for ascertaining capacity and making best interest decisions. Where they were in doubt they would activate the local NHS ambulance service.
- Where patients were not conveyed, they were left with non-conveyance cards advising them about what to do next.
- The provider did not convey patients who were subject to detention under the Mental Health Act.

Are emergency and urgent care services caring?

Compassionate care

- We observed responders respond to two calls during the inspection. We observed that patients were treated with dignity and respect and responders interacted with patients in a respectful and considerate manner.
- Responders we spoke with described how they ensured patients were treated with dignity including explaining procedures, asking for consent as well as ensuring patients were not exposed unnecessarily.
- We collected 17 comment cards from patients and all were positive about the care received. Staff were described as "calm and friendly" and "caring and respectful". One patient commented, "The paramedics…treated my mother with the utmost respect and dignity and carried her with great care".
- Patient calls were broadcast to all radios and we heard details of the patient's address and the nature of their illness or injury. Responders were asked to turn down the volume of their radios in public but managers could not fully assure themselves that patients' privacy was protected.

Understanding and involvement of patients and those close to them

- We listened to recordings of ten calls to the service and heard that dispatchers spoke to patients clearly and respectfully and explained what would happen next. Responders were sent for all calls so this involved reassuring callers that someone was on the way.
- We observed that patients' relatives were involved in their care where appropriate such as in supplying information. Relatives were given the option of traveling in the ambulance with the patient.

Emotional support

- We heard and observed dispatchers and responders providing support to callers and patients in distressing situations. We were assured from our conversations with responders that they had a good understanding of the impact of care on patients' wellbeing.
- All staff involved in distressing calls such as cardiac arrests would be debriefed afterwards and supported by managers. There was a mobile phone group chat where responders supported each other.

Supporting people to manage their own health

- Hatzola Northwest provided a service to a small local community. Responders described getting to know frequent callers and identifying vulnerable people in the community who they could then further support with advice or referral to alternative community services.

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

Service planning and delivery to meet the needs of local people

- Hatzola Northwest was funded and run by the local Jewish community which it served and the service was planned to meet their needs, though they would respond to anyone who phoned the service from within the area they covered.
- The service had links with the local NHS ambulance service which supported them with training. If the service was unable to meet demand patients would be referred to the NHS ambulance service.
- Managers informed us that the service had enough volunteers to answer and respond to the volume of calls received.

Meeting people's individual needs

- Responders demonstrated a good understanding of the needs of patient groups including those with mental health problems, those living with dementia and a learning disability. They described having responded to multiple patients with mental health problems and developing skills in this area based on experience. Although dementia training did not form part of the mandatory training of volunteers, they did receive training on mental capacity and responded frequently to calls from patients living with dementia and so developed an understanding in this area from experience.
- There was specialist lifting equipment available for lifting and transporting bariatric patients.
- There were pre hospital care books with pictures on ambulances which could be used as communication aids for patients who were hard of hearing.
- There was a telephone interpreter service available to call handlers and responders where patients did not speak English. Many call handlers were fluent in languages including Yiddish and Hebrew.

Access and flow

- The service operated 24 hours a day, 7 days a week all year round. There were 17 dispatchers and 41 responders who responded to calls. Call handlers were expected to follow a set protocol when they answered the telephone to identify the problem and location of the caller. Call handlers did not undertake any triage of calls as responders were always sent in response to any medical concern or query.
- There was an average of 9.3 calls per day within the reporting period. We observed that calls were answered the dispatched promptly and were told by staff we spoke with that the new computer aided dispatch system had improved this.
- Managers informed us they were planning to measure arrival at hospital times for stroke, heart attack and major trauma patients.

Learning from complaints and concerns

- The service had a complaints procedure. Clients could complain by email, telephone or on the service's

website and all complaints were handled by the general manager. Information about how to complain was displayed in ambulances on posters and was clearly displayed on the organisation's website.

- There had been no formal complaints received by the service in the reporting period. We were told that any informal complaints would be treated as an incident and investigated accordingly.

Are emergency and urgent care services well-led?

Leadership and culture of service

- The service was led by a general manager and a clinical lead who were overseen by a medical director and a trust board.
- There was a management committee elected from Hatzola North West responders responsible for overseeing the governance of the charity and ensuring the financial stability of the organisation. Individual areas of work such as safeguarding, infection prevention and control and health and safety were overseen by allocated leads in these areas.
- The day to day running of the service was managed by the general manager who oversaw the administrative functions of the organisation, the implementation of the call handling system and managed call takers.
- There was a clinical lead who managed responders who responded to calls, oversaw medical protocols and carried out audits. The clinical lead was a professional paramedic, they were overseen by a medical director whose primary function was to advise the clinical lead and sign off on policies and protocols, the medical director also reviewed serious cases and incidents.
- There were two paramedic team leaders who were employed on a freelance basis and were responsible for delivering training and supporting volunteer responders.
- All responders we spoke with told us that leaders of the service were visible and easily contactable in case of emergencies or concerns. Responders we spoke with told us they felt listened to and could contribute their views about the running of the service.
- Responders we spoke with were proud to volunteer for the service and to provide a service for their community. They described a positive, supportive working environment in the organisation.
- Managers had a good understanding of the challenges and shortcomings of the service and clear strategies for improvement.

Vision and strategy for this this core service

- The vision and strategy was based on four outcomes: exceptional patient experience, partnerships that make a difference, a great place to volunteer or work and a high performing organisation.
- The plan for the service was to recruit more volunteers and build on the improvement work that had been done to continue provider a high level of service to the community.
- All volunteers we spoke with understood the vision for the service and their role in achieving it.

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

- The management committee met monthly and discussed the strategy for the organisation, staffing and other issues as well as standing agenda items such as health and safety and incident reporting.
- There were governance systems in place to identify and monitor issues and risks within the organisation including a comprehensive risk register which was managed by the board.
- There were 37 entries on the risk register, many of which were reflective of what we found on inspection such as mandatory training not being up to date for all responders and inconsistent following of the call response procedure.
- Managers identified areas for improvement and service development and had plans for achieving these changes to the service.
- Roles and accountabilities for managers and the board were clearly defined and staff we spoke with were clear about how the organisation was run.

Emergency and urgent care services

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

- Responders of Hatzola used mobile phone group chats to keep in touch and offer each other support and advice.
- However, there were no regular meetings for responders and dispatchers. The service relied on ad hoc communication with and between volunteers.
- Hatzola funded community training days where responders of the service gave presentations about how and when to contact Hatzola and paramedics from the London Ambulance Service gave first aid training.
- The service carried out a staff survey to gather the views of volunteers about all aspects of their involvement in the service. The survey showed that staff enjoyed volunteering for the service and felt involved. There was also a box for them to make suggestions such as extra training.

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

- The service depended on donations from the local community to ensure the organisation was financially sustainable, Hatzola had recently held a successful fundraiser. They planned to invest the proceeds in a fourth ambulance vehicle.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should regularly record ambient room temperatures in areas where medicines are stored to ensure they do not exceed recommended the temperature range recommended by the manufacturer.
- The provider should ensure they are following their infection prevention and control audit policy and refer members scoring less than 75% to the clinical lead for further training.
- The provider should ensure that all single use equipment is in date.
- The provider should ensure that dispatchers follow the provider policy and national best practice when handling calls.
- The provider should consider a system of formal supervision and appraisal for dispatchers.