Gateshead Hatzola office

Quality Report

7 Bewick Road
Gateshead
NE8 4DP
Tel:01914325223
Website:dkatz@hatzola.org.uk

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Overall summary

Gateshead Hatzola office is operated by Gateshead Hatzola . The service provides remote advice and triage under their registration as a patient transport service.

We inspected this service using our comprehensive inspection methodology. We conducted an unannounced visit to the service on 11 February 2020.

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

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

The service had not been inspected or rated since registration. We rated it as **Requires improvement** overall.

- The call taker/ dispatchers and responders had not attended accredited safeguarding training or had a formal safeguarding qualification from an accredited training provider.

Summary of findings

- The provider did not have a system or process in place which covered daily equipment checks on their ambulance.
- The provider did carry out infection prevention control audits, vehicle cleaning audits, vehicle deep cleaning audits and hand hygiene audits.
- The providers patient record forms (PRF) did identify patient risk but did not include an overall patient risk assessment and what response to take in relation to that overall risk.
- The providers PRF did not contain hospital handover information.
- The provider could not guarantee confidential patient information was not being seen by people outside Gateshead Hatzola because of the existence of a carbonated copy of the PRF.
- The provider did not store medication with the original packaging and patient information leaflet.
- The provider did not have a policy for patients being transported to hospital with their own medication.
- The provider did not have any key performance indicators which could be audited and reviewed to improve service delivery.
- The providers major incident plan had not been tested by way of exercise or practically since the service had registered with CQC.

However, we found the following areas of good practice;

- The provider had a robust system of asset tagging.
- The provider had fall back systems for the telephony which ensured the service would not be lost.
- The provider had strong links to the community served.
- The provider had secure management of information.

Following this inspection, we told the provider that it must make 13 improvement and should make four other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected Patient Transport Services. Details are at the end of the report.

Name of signatory

Ann Ford

Deputy Chief Inspector of Hospitals (area of responsibility), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	**Requires improvement** 	Patient transport services were the only regulated activity. Between 1 January 2019 and 22 December 2019 528 calls were responded to, of these, only 26 received an ambulance response. The other calls were not for regulated activities and the figures included calls that preceded registration.

Summary of findings

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Summary of this inspection

Background to Gateshead Hatzola office

Gateshead Hatzola office is operated by Gateshead Hatzola . The Gateshead Hatzola was formed 29 years ago, and the service first registered with CQC in March 2019. The service has had a registered manager in post since March 2019.

Gateshead Hatzola is funded by charitable donations from the Jewish community and donations of equipment from benefactors.

It is a voluntary independent ambulance service in Gateshead, Tyne and Wear providing 24 hour 365 days per year medical support. The service primarily serves the Jewish community in the Bensham area of Gateshead. The community live roughly in a one square mile area and there are approximately 600 families living there with an average family size of 6.4. In addition, during college term time there are an additional 1,500 Jewish students from around the world living in the same area.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,one other CQC inspector, and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Gateshead Hatzola 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 operating base. We spoke with six staff including three responders, the registered manager, nominated individual and the clinical lead. We spoke with one patient. During our inspection, we reviewed 12 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. The service had not been inspected since it was registered.

Activity (January 2019 and 22 December 2019)

- There were no patient transport journeys undertaken.
- Between 1 January 2019 and 22 December 2019, 528 calls were responded to, of these, only 26 received an ambulance response. The other calls were not for regulated activities and the figures included calls that preceded registration.

All the staff who worked for Gateshead Hatzola were volunteers none were employed. At the time of the inspection there were eight call taker/dispatchers and 22 responders, 20 of whom were trained to drive an ambulance. The responders were trained to First Response Emergency Care (FREC) level three. The QA Level 3 Certificate in First Response Emergency Care (RQF) is a regulated and nationally recognised qualification specifically designed for those seeking a career in the emergency services, ambulance service, the event and security medical sector or those who work in high risk workplaces.

Track record on safety

- No Never events
- No Clinical incidents, no harm, no low harm, no moderate harm, no severe harm, no death

Summary of this inspection

- No serious injuries

One complaint was received in the reporting period but was withdrawn as it did not apply to Gateshead Hatzola.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Patient transport services

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

Are patient transport services safe?

Requires improvement

The service had not been inspected or rated since registration. We rated it as **requires improvement.**

Mandatory training

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

The provider used a spreadsheet for staff which included dates of course attendance.

The provider told us because all the staff were volunteers, they did not designate training as statutory and mandatory. However, all responders were trained to FREC 3 (First Response Emergency Care Level 3), which was refreshed every three years.

Managers told us any volunteer who had not done the refresher training would not be allowed to work for Hatzola until they had done so.

Staff carried out annual First Responder basic life support (BLS) refresher, which 22 staff attended on 24 July 2019. This training was provided by a local NHS ambulance provider.

Other required areas such as infection control and Mental Capacity Act compliance were refreshed annually.

There were other courses staff had attended which were on the spreadsheet, which included; Blood glucose, liquiband, nursemaids' elbow, unwell child which six staff attended on 10 April 2019. Manual handling for ambulance which 22 staff attended on either 5 May 2019 or 10 May 2019. Child and adult safeguarding refresher, which 22 staff attended on 13 January 2020. Mental capacity and Deprivation of Liberty Safeguards (DoLS) refresher which 22 staff attended on 13 January 2020. Infection controls refresher, which 22 staff attended on 13 January 2020 and duty of candour refresher, which 22 staff attended on 13 January 2020.

The spreadsheet did not outline when the next set of courses were or when refreshers would be held because this was the first year the service had been registered.

Safeguarding

We saw evidence the designated safeguarding lead had completed an on-line course dated 16 May 2019 and a safeguarding adult's level two course and level three course for children.

The deputy safeguarding lead had completed a level three designated safeguarding officers' course and a safeguarding adult's level two course.

The designated safeguarding lead sat on the Gateshead Safeguarding Children Partnership Board.

Responders received annual safeguarding training from the designated safeguarding lead, however, the training was not accredited, and the responders did not have a safeguarding qualification.

Following post inspection feedback, the provider had sourced an on-line safeguarding adults' level two and safeguarding children levels one and two courses for staff to complete which had an accredited qualification. We saw evidence two responders had completed the course.

Requires improvement

Patient transport services

We reviewed the providers power point presentation for staff in relation to child protection guidelines for staff dated 2019. The presentation gave staff background information as to what would constitute a safeguarding matter.

The provider had not made any safeguarding referrals in the reporting period; however, we were given an example of a concern raised by a responder which was reviewed by the safeguarding lead and correctly not referred.

The providers safeguarding policy was in date and provided responders with information as to how to make a safeguarding referral.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and premises visibly clean.

In a small office used as a storage area for cleaning products next to the ambulance parking bay there was mops and cleaning products which evidenced the provider followed the British institute of cleaning science and national patient safety (2016) colour coding systems for identifying which cleaning products to use on which areas of the vehicles or buildings.

There were facilities such as a sluice for the disposal of waste liquids after cleaning vehicles.

There were no facilities for the disposal of clinical waste at the providers base, however, there was a formal arrangement with a local NHS ambulance provider for Hatzola staff to dispose of clinical waste at a local ambulance station. We saw a supply of empty clinical waste bags and staff we spoke with were aware of the process of disposing of clinical waste.

The ambulance we inspected had a sharps bin and a bin for the collection of clinical waste which were different colours, however, neither was labelled. We informed the provider who took immediate action to rectify this.

There was additional linen stored on the provider's operational ambulance. Managers told us staff disposed of used linen and collected replacements at a local NHS ambulance station.

When we inspected the provider's ambulance, we found a small tear in the trolley mattress which was pointed out to the provider who took immediate action to replace it.

The ambulance had a supply of disinfectant wipes and hand cleansing gel, which staff were observed using both before and after patient contact.

There was evidence in the vehicle log book which showed the vehicle had been subject to cleaning after use. The ambulance had not been deep cleaned since the service was registered, however, we saw evidence it was booked in with a company which was a subsidiary of a local NHS ambulance provider to be deep cleaned. This was in accordance with the providers policy

Responders had been given local training on infection prevention control.

Since registration the provider had not carried out any infection prevention control audits, vehicle cleaning audits, vehicle deep cleaning audits or hand hygiene audits.

Managers told us because of their operating model responders attend calls often dressed in their own clothing. It was recognised this could be an infection prevention control issue if the responders clothing had become soiled or contaminated and they had not changed prior to attending another call. The provider did not have a specific policy in relation to this, however, this was included in the infection control policy and procedure.

Responders always carried their own first aid bags. We were able to inspect the contents of two bags which had been held in reserve at the operating base. Both contained hand gel and wipes.

The operating base was a single office and was not an operational area therefore it was kept clean and tidy in a conventional way and not subject to specialist cleaning.

Environment and equipment

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

The providers' operating base was a rented third floor office in the Bensham area of Gateshead. The main entrance and internal door had a key pad lock. The office was used for the storage of consumable items which were in lidded plastic boxes labelled and bar coded. There was enough stock for the services provided. Staff we spoke with told us there was never a problem replacing items which had been used. The office was used for meetings and there was a lap top computer for staff and managers to use.

Patient transport services

There was welfare facilities for staff on the ground floor including a kitchen and toilet.

The provider used a bar coding system/ asset tagging system for equipment. When staff needed to replace consumable items, they logged onto the asset register system then used a bar code reader on the front of the box in which the item was stored. Each item had a unique code. The removal of an item was recorded by name against the person taking it and the central database with all the consumable items listed up dated as being one less against the items taken. There was a limit set as to how many of each item should be held in stock and once the limit was reached an email alert would be sent to the registered manager who would then replace the items.

There was not a separate consumable item recording system on the ambulance, however, because the provider had only one ambulance there was no need for a secondary system.

The same system was used for responders to replenish any used consumable items in their first aid bags.

The electronic equipment on the ambulance had portable appliance testing (PAT) service stickers which evidenced they were in date. The electrical equipment was recorded on the same asset register as the consumable items. The register recorded when the equipment required re-testing and servicing. When these dates were reached an email would be sent to the registered manager who would arrange the re-testing or servicing.

The provider's ambulance was parked in a service yard of an office block near to the operating base. The service yard had large metal gates which were locked. The yard was accessed through a key fob which all the volunteers possessed. The yard was covered by CCTV. In addition, the building in which it was housed had 24/7 security with regular patrols. The vehicle keys were stored securely. The office had a key pad lock as did the key box. The number combinations for the locks were only known to Hatzola staff.

The provider's ambulance was inspected. Both the interior and exterior appeared visibly clean. The vehicle lights, doors, ramp and radio were in working order. The vehicle servicing and maintenance was done through a local NHS ambulance provider. We saw evidence these were up to date.

The ambulance contained reusable and consumable items which were all in date. The ambulance had a supply of clean linen, bins for sharps and clinical waste, hand cleansing gel, wipes and sterile supplies which were in date. There was personal protective equipment but no goggles or FFP3 facemasks. We saw evidence on inspection these had been ordered.

FFP3 Dust Masks protect against higher levels of dust and solid and liquid aerosols. The Health Protection Agency (2009) advised people with flu to use face masks when they are in contact with other people and healthy people to wear a face mask when they are caring for a person with flu in non-clinical situations.

The ambulance did not have an equipment check list, however, the equipment was recorded on the provider's asset register.

The ambulance vehicle check list lacked some detail, for example, there was a tick box for the tyres being checked. There was no mention the tyre pressure and tread depth had been checked.

The ambulance carried vehicle harnesses and chairs for safely transporting children.

In the ambulance there was 360-degree camera which had a recording facility. There was a notice displayed in the ambulance explaining to patients, relatives or carers they were being filmed displayed.

Volunteers who worked as call takers/dispatchers had two mobile phones each linked to a different provider. This meant if one network went down, they could use the other one. In the operating base we were shown a mobile radio transmitter which could be used in the event of failure of the radio system.

The call takers/dispatchers' phones were set up so that if a call had not been answered it went to the registered manager who would deal with the call. In addition, we saw evidence of daily line checks to ensure the telephony was working.

Assessing and responding to patient risk

All calls received the same level of response, except when the dispatch standing operating procedure (SOP) indicated additional resources should be assigned.

Requires improvement

Patient transport services

The call takers/dispatchers had a clear algorithm to follow. In summary, the call taker obtained the patients details, home address and what the condition of the patient was before dispatching a responder to the scene as fast as possible.

There was a clear process for the call taker/dispatcher to refer calls to an NHS ambulance service by advising the caller to do so. Call takers/dispatchers did not request an NHS ambulance themselves simply because they were not trained to the same level as NHS ambulance call taker/ dispatchers and therefore did not triage the call. In addition, because they were not present with the patient, they could not provide clinical observations and the call would not receive an emergency response.

In accordance with the dispatch SOP all calls for unresponsive and non-breathing patients the callers would be advised to call 999 to obtain an NHS ambulance. A Hatzola responder would be dispatched to the patient to ascertain what care they could provide in accordance with their FREC3 training while awaiting an NHS ambulance.

Responders could provide a more in-depth accurate picture of the condition of the patient if an NHS ambulance call taker rang them back and when an NHS ambulance crew attended the call because of their training.

The provider had a SOP for non-conveyance of patients. The document was approved in December 2019 and had a review date of December 2021. There was no information as to who the author was and there was no version control.

In point five of the SOP, it stated, if you (the responder) wish to consult with a clinician before deciding whether to leave a patient at home, you can contact the clinical director (text him initially) or call 111 and ask to speak to an NHS clinician. Document the advice you receive and who has given it on your PRF.

There was evidence of a system to review the decisions made by staff in relation to the standard operating procedure. All calls were recorded, and the registered manager told us they either listened to the live call or a recording. They estimated listening and reviewing at least 50% of all the calls received.

When a call was identified where there could be improvement a call review form was completed which identified where improvements could be made. This was approved by the clinical director before being shared with the volunteers. The main issue identified was incomplete information.

We reviewed the call takers/dispatcher's operator form and the patient record forms (PRF). Both did not have an overall patient risk assessment and associated response.

On the PRF there was a section for primary survey which included catastrophic bleeding, airway, breathing, circulation and observations which identified the risk to the patient.

During inspection we reviewed 12 PRFs. All had evidence that the responder had not acted outside their qualification when dealing with the patient.

We saw evidence that if a patient was not in need of urgent emergency care, for example needed a cut stitching or possibly should have an x-ray Gateshead Hatzola staff would take the patient to hospital to save the patient having to drive themselves or have to wait for an NHS ambulance.

If a patient did require urgent emergency and transport to hospital this would be done by a local NHS ambulance provider or an NHS ambulance provider paramedic would travel with the patient in the rear of the Hatzola ambulance. The clinical director confirmed this was the SOP for the service.

We saw evidence responders were issued with a Hazola responder handbook which would be best described as an abridged version of Joint Royal Colleges Ambulance Liaison Committee. (JRCALC). The content of the booklet would provide staff with information to assess and manage patient risk.

The booklet we reviewed was version 2.1 having been updated in January 2020.

Hatzola responder handbook contained information in relation to national early warning scores (NEWS2) and the thresholds and triggers as to how to respond. There was also a section covering the paediatric assessment triangle and what actions responders should take.

There was information for responders to follow and action to take in relation to meningitis and sepsis.

Staffing

Requires improvement

Patient transport services

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

Everyone who worked for Hatzola including the managers were volunteers.

At the time of the inspection there were eight volunteer call taker/dispatchers and 22 volunteer responders trained to FREC3 level, 20 had been trained by a local NHS ambulance provider to drive ambulances.

There was no shift system for responders. All of them were on call and available 24/7 365 days of the year. The volunteer dispatchers worked 12-hour shifts, 9am to 9pm and 9pm to 9am.

Staff who were on holiday or were ill informed the registered manager and turned off their radio.

The managers told us if a call taker/dispatcher or responder had been busy or had dealt with a difficult calls or traumatic call they would ask them to take some time off. As the staffing levels were so high this would not impact upon service provision.

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

Records

During inspection we reviewed 12 PRFs. All contained accurate information, were complete, legible and up to date, however, on the PRFs for patients who had to go to hospital there was not a section for detailed patient handover information.

Responders were made aware of "special notes" in relation to pre-existing conditions or safety risks from the call taker.

Call takers had been instructed to ask callers if there was a do not attempt cardiopulmonary resuscitation (DNACPR) in place with the patient. This information would be passed on to the responder.

Both the operator report form and PRF had information boxes which contained all the information needed to deliver safe care and treatment.

The provider used administrative support to upload the information from the paper operator report form and PRF to a computer-based system which managers used to review them. The paper records were shredded after uploading.

Although the PRFs were marked as confidential and had a unique reference number they were on a pad of forms which were carbonated. When the completed PRF was removed the carbonated copy remained on the pad. This created a risk that confidential patient information could be seen by people outside Gateshead Hatzola.

The completed PRF was placed in a locked letter box in the operator's office. The letter box was emptied by the registered manager before being taken to the administrative support to upload.

Medicines

The provider did not use or store any controlled drugs and none of the volunteers were trained or qualified to administer controlled drugs.

The provider had oxygen and nitrous oxide which were kept secure on the ambulance. There was a formal arrangement in place with a local NHS ambulance provider to exchange empty medical gas cylinders at a local ambulance station.

The provider did use aspirin and salbutamol. We found these were not kept in the original packaging and did not have the patient information leaflet with them.

The provider had a medicines policy. This was not dated when it went live, when the review date was, who the author was and there was no version control.

The policy provided a framework of processes for all aspects of medicines management including supply, administration, storage, disposal and adverse incident reporting.

The following were the only medicines currently authorised to be used by responders: oxygen, nitrous oxide, salbutamol and aspirin.

These medicines were administered in accordance with the relevant SOPs developed in consultation with the clinical director.

Requires improvement

Patient transport services

Salbutamol and aspirin were not kept on the ambulance overnight. They were stored in lidded plastic containers in the provider's operating base.

The provider did not have a policy for patients being transported to hospital with their own medication. Managers told us the patient would be given a plastic bag by responders and the patient would carry the medicines themselves.

Responders treated patients with non-injectable (non-parenteral) prescription-only medicines. Although current legislation did not support this, the service assessed and managed the risk, trained staff and assessed them as competent. This ensured patients had timely access to safe and effective treatment.

There was evidence responders had received training and the provider had standing operating procedures for oxygen, nitrous oxide, aspirin and salbutamol which had been signed off by the clinical director.

Incidents

In the reporting period the provider had not recorded any incidents.

Managers we spoke with told us they felt confident staff knew how and when to report incidents.

The provider had an incident reporting policy. This was not dated when it went live, when the review date was, who the author was and there was no version control.

The policy included a blank incident report form, how to complete a risk assessment and the incident reporting procedure.

The provider had a duty of candour policy which was adopted by the trustees in March 2019 and was due a review in March 2022. The policy did not outline who the author was and there was no version control.

The policy highlighted the reporting procedures and roles and responsibilities in applying the principles of duty of candour. The provider had not had to apply the principles of duty of candour in the reporting period.

The duty of candour places a legal responsibility on every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress and to apologise to the patient or, where appropriate, the patient's advocate, carer or family.

Staff we spoke with could explain what the principles of duty of candour were and when they should be applied.

Are patient transport services effective?
(for example, treatment is effective)

Good

The service had not been inspected or rated since registration. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.

There was evidence people's physical, mental health and social needs were holistically assessed, and their care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes.

We saw evidence in the PRFs we reviewed that patients had their needs assessed and their care planned in accordance with the level of training of the responders.

This was monitored by the registered manager who reviewed all the PRFs.

There were suitable protocols available for children of all ages and other patient groups such as women which took account of the cultural and religious needs of the patient.

The patient's eligibility for the service was assessed upon receipt of the call and following an assessment by the responder. This could result in either Hatzola taking the patient to hospital if they were not an emergency or the patient would be taken to hospital by a local NHS ambulance service.

Alternatively, the patient would be treated if appropriate and left at home with appropriate advice.

Patient transport services

Responders were made aware of patients with mental health needs after the call taker/dispatcher obtained the details which were passed to them and recorded on the operator report form and PRF.

We saw evidence in PRFs where patients were told they should seek further help and were advised what to do if their condition deteriorated. The same advice was given to callers who did not want a responder to attend.

Nutrition and hydration

There was bottled water on the ambulance we inspected for patients to drink. There was no food provided.

All call takers and responders were aware of the cultural and religious food requirements of the patients because they were themselves of the same faith.

As any potential journeys to hospitals in the area were of a short distance there was no requirement to plan journeys and include meal stops.

Pain relief

Hatzola responder handbook contained information in relation to the paediatric pain scale using the Wong Baker faces so responders could asses the level of pain a child was suffering.

The PRFs contained a section for patient pain score.

Responders were trained to administer pain relief in accordance with their FREC3 training. In the PRFs we reviewed when pain relief had been administered it was clearly recorded.

Response times

All calls received obtained a response either by dispatching a responder unless advice only was requested, or caller refused to accept a response.

The provider recorded response times.

Managers told us they were confident the responders attended each call within two minutes. The SOP for the provider was at any time there was 22 responders in their own homes within the square mile where the Jewish community lived. When a call came in the responder who was nearest to the patient would attend the call. Therefore because of the geographic footprint where the service was provided and the high number of responders the response times will be low.

When we were on inspection, we listened to two live calls. On both the responder who attended got to the patient within two minutes.

Managers told us currently response times were not audited, however, work was ongoing to have all the PRFs made computer based and as such information such as response times could be easily obtained.

Patient outcomes

We saw evidence in the PRFs that the intended outcomes for people were being achieved.

The provider did not measure patient outcomes; however, they did record on the PRF what the outcome of the responder's attendance had been.

Managers told us currently patient outcome information was not audited, however, work was ongoing to have all the PRFs made computer based and as such information such as patient outcomes could be easily obtained.

Gateshead Hatzola did not work with other Hatzolas and therefore did not compare patient outcomes to other services.

The provider did not participate in relevant quality improvement initiatives, such as local and national clinical audits and benchmarking because of the unique service provided.

Competent staff

The service made sure staff were competent for their roles.

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

Volunteers were recruited where required and were trained and supported for the role they undertook.

The provider had a recruitment and induction policy. This was not dated when it went live, when the review date was, who the author was and there was no version control.

The policy explained the recruitment and induction procedure for staff.

The learning needs of all volunteers were identified following recruitment.

Requires improvement

Patient transport services

Staff had appropriate training delivered to meet their learning needs to cover the scope of their work.

We saw training certificates for five staff who all passed a first responder emergency care course in March 2019. The certificates included when their basic life support (BLS) refreshers were due and what the requalification date was.

All responders were trained to FREC 3. This allowed responders to administer oxygen, nitrous oxide, take a 12-lead electrocardiogram, measure blood sugar and blood pressure as well as defibrillating with an automated external defibrillator (AED). Responders were trained to use oropharyngeal and nasopharyngeal airways, but they could not intubate or cannulate.

We saw evidence all volunteers had a current disclosure and barring service check (DBS) and when the review date was.

We saw 20 training certificates from a course ran by a local NHS ambulance trust which qualified staff to be emergency response drivers.

The ambulance the provider used was under 3.5 tonnes and therefore staff could drive this vehicle on a standard driving licence. The C1 driving licence allowed people to drive vehicles up to 3.5 tonnes. Drivers who passed the 3.5 tonne C1 test become entitled to drive C1 rigid vehicles up to 3.5 tonnes with a trailer up to 750kg.

The provider had an annual appraisal and supervision policy. This was not dated when it went live, when the review date was, who the author was and there was no version control.

This policy would take full effect one year after CQC registration was achieved which was 29 March 2020, to enable an annual cycle to be established. Until that point, it was implemented on an ad hoc basis.

The co-ordinator/registered manager would be responsible for ensuring each volunteer or employee had an agreed personal development plan which would be reviewed annually and for carrying out observations to ensure agreed standards were being met.

There was a nominated individual identified to carry out the supervision process for the co-ordinator/registered manager. They were suitably qualified and experienced having worked for over 30 years for Gateshead Hatzola.

Calls from the public were recorded and call takers/dispatchers also completed a call report form. It was used to monitor response times, responder activity and quality of call handling.

Volunteers call takers/dispatchers at Gateshead Hatzola had in-house induction training and training on call handling delivered by a local NHS ambulance trust. Managers described the training as bespoke around call and caller management. There were no formal qualifications. There was evidence all current call takers/dispatchers had been trained.

The communications manager and the co-ordinator/registered manager supervised and assured the work of the call takers.

Managers described the call review process as being done informally because there was not an agreed set number of calls to be reviewed. The registered manager told us they estimated 50% of the calls were reviewed to identify any deficiencies which may result in additional volunteer training.

As none of the calls were triaged at the point of receipt and responders were sent to every call, the opportunity for formal review was limited.

However, we saw evidence the provider was formalising the assurance process. Volunteer teams met formally twice a year, and the opportunity was used by the co-ordinator to disseminate good practice points, lessons learned, or new procedures.

Outside of the twice yearly meeting the co-ordinator/registered manager and nominated individual were in regular close contact with the team by phone or email to assist and direct them as necessary.

The provider could not give any examples when a call taker/dispatcher had made an error on a call and what action was taken.

Managers recognised most often Hatzola served the local community and the call taker/dispatchers would tend to know the callers and the callers may recognise the dispatchers. One of the areas managers were vigilant about was that dispatchers did not allow their level of professionalism and confidentiality to be affected by pressure or perceived pressure by a caller whom they may know well.

Requires improvement

Patient transport services

Multidisciplinary working

The Gateshead Hatzola worked very closely with a local NHS ambulance trust who supported them with training and logistics in relation to equipment.

The local NHS ambulance trust had a clear understanding of the Gateshead Hatzola operating model.

On occasions following the attendance of an NHS ambulance at a call where a member of Hatzola staff was present the NHS ambulance crew member would travel with the patient in the rear of the ambulance to hospital.

Health promotion

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

The provider gave examples of when they had community events and delivered awareness training for the public in relation to dealing with a cardiac arrest.

The provider had also recognised an issue by their calls and attending to patients of some children being scalded on the Jewish sabbath. This had occurred because Jewish families were not allowed to use electricity on the Sabbath in accordance with their beliefs and so stored hot water the day before in an urn or similar container. Some children had suffered scalds from these receptacles.

Hatzola had circulated this information to the community and provided advice to prevent scalds. This reduced the scalds suffered in such circumstances to zero.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The provider had a mental capacity and deprivation of liberty safeguards policy.

This was not dated when it went live, when the review date was, who the author was and there was no version control.

The policy covered the mental capacity act and deprivation of liberties safeguards procedures, the five statutory principles, consent and capacity, consent to care, best interest decisions, advance decisions, lasting power of attorney (LPA), independent mental capacity advocate (IMCA), restraint, record keeping, interface with the mental health act (MHA) 1983, deprivation of liberty safeguards (DoLS) 2009, training and development, role and responsibilities and policy guidance.

The Hazola responder handbook provided volunteers with information and action.

Are patient transport services caring?

Good

The service had not been inspected or rated since registration. We rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Managers call taker/dispatchers and responders all understood and respected the personal, cultural, social and religious needs of the community and how these related to care needs and did take these into account in the way the service was delivered.

The provider had a close working relationship with a local NHS ambulance provider who this information was shared with.

We observed volunteers took the time to interact with a patient who used the service in a respectful and considerate way.

We listened to two live calls and two recordings which evidenced the call taker/dispatcher took the time to interact with the caller in a respectful and considerate way.

As volunteers were from the same Jewish community and were aware of the cultural and religious needs, they made sure that people's privacy and dignity needs were understood and were always respected, including during physical or intimate care and examinations.

Requires improvement

Patient transport services

The provider had produced a briefing document for NHS ambulance crews which explained the cultural and religious needs of Jewish patients should an NHS ambulance crew had to attend a call in the Jewish community.

There was evidence in the short time taken to respond to calls and getting a responder to the scene that volunteers responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

The number of calls that resulted in a patient being taken to hospital was 26 out of 528 calls or 4.92%. The rest were dealt with either by providing advice and support at the point of the call or when the responder attended to the patient which evidenced patients were dealt with in a timely and appropriate way and received appropriate support.

Volunteers told us many of the calls received were for advice only and some were not related to medical issues.

As the volunteers were part of the Jewish community and knew the families, they understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially.

Volunteers were observed while on inspection providing emotional support to a patient.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We observed responders communicating with a patient so that they understand their care, treatment and condition and provided advice.

During inspection we listened to two live calls. On both calls the call taker communicated with the caller so they understood the advice provided.

The provider had accessible ways to communicate with people when their protected equality or other characteristics made this necessary. A multilingual clinical phrase book was carried on the ambulance. Additional translation services were available by telephone on a pay-as-you-go basis from interpreting translation and language services (ITL).

As the service provided was based in the Jewish community patients' carers, advocates and representatives including family members and friends were, identified, welcomed, and treated as important partners in the delivery of care.

The providers hospital liaison officer was an honorary chaplain at local hospitals and was member of a community patient advocacy service. This enabled the Gateshead Hatzola to provide a high standard of continuity of care to patients as well as support to their families throughout the patient journey.

Are patient transport services responsive to people's needs?

(for example, to feedback?)

Good

The service had not been inspected or rated since registration. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The service was not commissioned or contracted.

The Gateshead Hatzola was the Jewish community`s volunteer ambulance service providing 24 hours cover 365 days of the year for the local Jewish community specifically in the Bensham area of Gateshead.

Managers told us the Jewish community would contact Hatzola before an NHS ambulance for three reasons; if the call was non-urgent and for advice only because the call taker had the same religious beliefs as the caller the advice was taken, if the call was urgent the caller would be guaranteed a response within two minutes and the volunteers knew what the cultural needs were on the Jewish sabbath.

Requires improvement

Patient transport services

The services provided reflected the needs of the population served and did ensure flexibility, choice and continuity of care.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

The majority of Hatzola patients were members of the Jewish community, as were all the volunteers. The services were tailored to meet their spiritual needs, for example Sabbath observance. Hatzola had arranged for the provision of a dedicated Sabbath room in one local hospital and a Sabbath box in others.

Managers and volunteers, we spoke with told us as members of a minority community themselves they had a deep respect and understanding for other minority groups and endeavoured to meet their spiritual needs whenever possible, save that life-saving activities took precedence.

Hatzola had produced guides to the Jewish community for ambulance service and a briefing document for NHS ambulance crews and hospital personnel to assist them in understanding the spiritual and cultural needs of their Jewish patients.

We were shown evidence of when Hatzola responder volunteers had provided medical care to patients who were not Jewish.

Most residents in the Jewish community spoke English, at least as an additional language. As all the responders were drawn from the Jewish community, they were able to speak Hebrew or Yiddish if required.

A multilingual clinical phrase book was carried on the ambulance. Additional translation services were available by telephone on a pay-as-you-go basis from interpreting translation and language services (ITL).

Patients living with; a learning disability, mental health illness, dementia, were bariatric patients, were hard of hearing or deaf or were partially sighted or blind were identified by the call taker and those details added to the operator report form. This information would be shared with the responder.

Access and flow

Anyone requiring the services of Hatzola had a local contact number to ring. The service did not have an appointment system, was totally reactive and all calls received were responded to either by providing telephone advice or the attendance of a responder.

Managers told us the telephone number was known within the local community but not widely known outside the local community simply because the service was designed and operated to specifically to serve the local Jewish community, however, Hatzola would respond to the needs of all patients, regardless of faith or ethnicity.

In some cases, responders would come across incidents in public places or would be approached directly by neighbours and because responders always carried their first aid bags with them, they would deal with the patient.

As the service provided was specific to the Jewish community and in a small geographic area and the number of volunteers were high this minimised the length of time people had to wait for care, treatment, or advice. In addition, because of the level of understanding of religious and cultural needs the advice provided was in accordance with these.

There was not a process where the most urgent needs had their care and treatment prioritised because there was not any delays in taking any calls and every call would result in a responder being sent to the scene unless the call declined this.

Managers told us very occasionally they were contacted directly by local GPs who requested patients who were not urgent cases be transported to hospital for appointments.

Calls for the service were received by telephone through a Voice over Internet Protocol (VoIP), also called IP telephony, which is a method and group of technologies for the delivery of voice communications and multimedia sessions over Internet Protocol networks, such as the Internet.

The VoIP virtual switchboard was monitored by volunteers.

The service used a cloud-based hosted service from a commercial provider. Incoming calls were diverted to the virtual switchboard which then distributed them to a number of mobile phones simultaneously. Every call taker used two mobile phones on different networks to provide resilience. The switchboard recorded the incoming calls and would alert the co-ordinator/registered manager and the communications manager if a call was unanswered.

Requires improvement

Patient transport services

The call takers/ dispatchers and responders were available 24hrs a day 365 days of the year.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The provider had a complaints policy. The policy was not dated when it went live, when the review date was, who the author was and there was no version control. The complaints policy was available on the provider website.

The document explained how complaints could be received and how they would be investigated.

There was one complaint received in the reporting period which was withdrawn as it did not relate to Gateshead Hatzola.

There was a notice about complaints in the ambulance we inspected, and copies of the policy were carried by responders to be given to patients/relatives if requested. As all the volunteers and trustees were members of the local community, they could easily be approached with informal complaints and would inform the complainant of the complaints process.

Are patient transport services well-led?

Requires improvement

The service had not been inspected or rated since registration. We rated it as **requires improvement.**

Leadership

Gateshead Hatzola was both a registered charity and a body delivering healthcare. Trustees were ultimately responsible for the functioning of the organisation.

There were four trustees. One was the nominated individual, the others were a chartered accountant with responsibility for finance, a retired general practionner and a teacher who was originally one of the founders of Gateshead Hatzola. All were volunteers.

The trustees met every month. We saw evidence in the meeting minutes of the board of trustees the meeting had a set agenda, a review of the previous minutes and actions.

The provider had a fit and proper persons policy. This was not dated when it went live, when the review date was, who the author was and there was no version control.

The purpose of the policy was to outline the processes in place to ensure that the trustees of Gateshead Hatzola met the fit and proper persons criteria of the Charity Commission and CQC.

The leaders we spoke with demonstrated they had the skills, knowledge, experience and integrity to manage the organisation.

It was clear leaders understood the challenges to quality and sustainability, and they could identify the actions needed to address them.

Leaders were visible and approachable because they lived and worked within the local Jewish community.

Vision and strategy

There a clear vision and a set of values, with quality and sustainability as the top priorities.

Progress against delivery of the strategy and local plans was monitored and reviewed, and there was evidence to show this.

The provider had a strategy plan with 23 areas which outlined which business area it rested in, priority rating, trustee ownership, member ownership, description, justification of priority rating, progress update, actions to take and schedule for review.

The statement of purpose from the constitution of the charity was; the advancement of health and saving of lives by providing for the public benefit in Gateshead and the surrounding areas;

(i) a volunteer emergency medical first response and ambulance service

(ii) relief and assistance for persons who are ill or sick or otherwise in need of medical care and attention or hospital, clinical or nursing services and

(iii) information, education and training to promote health, safety and first aid and pre-hospital skills

The provider's mission statement was to provide quality care for the community.

Requires improvement

Patient transport services

Managers we spoke with knew and understood what the vision, values and strategy were, and their role in achieving them.

Culture

There was a strong culture within the organisation based upon the religious and cultural needs of the Jewish community.

This was evidenced by the fact all the people who worked for Gateshead Hatzola were volunteers.

Staff development was achieved through training, performance reviews and feedback, appraisal and career development conversations.

There was a strong emphasis on the safety and well-being of staff. Managers and the clinical director gave examples where calls with staff had been debriefed as they had been distressing. Managers also gave examples where they had stood staff down after dealing with a traumatic call.

In the briefing document for ambulance crews there was a full explanation of the cultural and religious needs of the Jewish community.

The provider had a whistle blowing policy. This was not dated when it went live, when the review date was, who the author was and there was no version control.

Although Gateshead Hatzola was a voluntary organisation and therefore not covered by the Public Interest Disclosure Act 1998, Gateshead Hatzola wished to comply with the spirit of legislation. Therefore, it would provide protection for volunteers or employees who raised legitimate concerns about specified matters in the public interest called qualifying disclosures.

Governance

The trustees met every month. We saw evidence in the meeting minutes of the board of trustees the meeting had a set agenda with standing items for discussion and reporting on. There was a full financial report every month because Gateshead Hatzola was charity and accountable to the charity commission.

The provider had a governance policy. This was not dated when it went live, when the review date was, who the author was and there was no version control.

The policy outlined the governance processes and responsibilities of Gateshead Hatzola.

The policy highlighted the trustees had primary responsibility for running the organisation. Their decision on all matters was final, subject to the relevant legislation and regulations and the provisions of Jewish Law as interpreted by the Rabbinical authorities recognised by Gateshead Hebrew Congregation.

There was evidence of effective structures processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services which was managed through the trustees meeting and strategy plan.

All levels of governance and management functioned effectively and interacted with each other appropriately.

There was not a system or process to record the working hours of volunteers in Gateshead Hatzola.Managers told us the volunteering ethos was deeply embedded in the Jewish community. Volunteers gave their time freely and would find it offensive to be asked to complete timesheets or to be monitored in any way.

In addition, as responders who were on call whenever they had their radios switched on although they may not be actively responding to a call, it would be almost impossible to measure this accurately.

Management of risks, issues and performance

The provider had a major incident plan. This was not dated when it went live, when the review date was, who the author was and there was no version control. The plan appeared to contain generic advice with role of Hatzola inserted.

The major incident plan has not been tested by way of exercise or practically since the service had registered with CQC.

The provider had a risk register with 15 risks identified. Each risk had a category, possible consequence, probability, impact, risk before mitigation, mitigation, risk after mitigation, responsibility, review due, date opened and last review.

All the risks were assessed as low. The risk register was discussed at the trustees meeting.

There was a system to monitor quality, operational and financial processes, and systems to identify where action should be taken. This was achieved by reviewing calls, PRFs and as agenda items at the trustees meeting.

Patient transport services

Information management

Managers told us personal sensitive information obtained at the time of a call was managed appropriately.

The process was the completed dispatcher reports and PRFs were dropped off into a locked, secure box, which was situated in a locked room at the providers operating base.

The responders would return to the operating base once they had completed the job to leave the PRF in the locked box.

If the dispatcher was unable to go there themselves, they would call the co-ordinator to collect the reports and take them to the locked box.

From that locked box, they were taken to a volunteer who worked as administrative support to be uploaded. They were delivered in a combination locked briefcase. The information was uploaded onto an encrypted memory stick which was stored in the locked briefcase when not in use.

The data was backed up onto an encrypted cloud server.

Once the paper documents were uploaded, they were immediately shredded.

We saw evidence the volunteer who worked as administrative support had signed a confidentiality agreement.

Call taker/dispatchers were aware of the need for confidentiality and ensured that they are not overheard when handling calls. This was included in induction training.

Information obtained from members of the public who called Gateshead Hatzola was recorded on a secure database and held and processed in accordance with the providers information governance policy.

The information governance policy was reviewed and adopted by trustees in May 2018. The policy was last reviewed in February 2020 and had a review date of February 2022.

The purpose of the policy was to protect patient and donor data by ensuring that Gateshead Hatzola complied with the requirements of the General Data Protection Regulation (GDPR), the Data Protection Act 2018 and other relevant legislation and guidance as well as the regulations set by the Care Quality Commission.

The provider did not have or collect any key performance indicator information.

Public and staff engagement

A programme of obtaining patient feedback had only been introduced recently. Current results were 100% either extremely satisfied or satisfied, 83% (five responses) were extremely satisfied and 17% (one response) was partially extremely satisfied and partially satisfied.

The provider held twice a year community events which had food and entertainment. This afforded the opportunity to deliver advice to the community on such matters as to how to deal with a cardiac arrest and to outline what services the Gateshead Hatzola provided.

The provider produced a magazine called “The Voice of Gateshead Hatzola”. The magazine had an editorial and various item highlighting the work of Gateshead Hatzola. This was free and delivered to the local community.

The Gateshead Hatzola had produced a briefing document for ambulance crews which explained the religious and cultural needs of the Jewish community.

Innovation, improvement and sustainability

Managers recognised that as a charity relying on financial donations and donations of equipment was always a challenge. The trustees had agreed never to let their financial contingency fund to go below £10,000.

The provider had produced a booklet called “The book of life” which had pictures, names and cost of essential equipment which highlighted to the community the costs involved in sustaining the service.

The manager told us they had engaged with the public to raise funds requesting they donate £18 per month for 18 months. In gematria (a form of Jewish numerology), the number 18 stands for "life", because the Hebrew letters that spell chai, meaning "living", add up to 18.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The providers call takers/dispatchers operator form and the patient record forms (PRFs) must include a patient risk assessment. This in relation to Regulation 12.
- The provider must have a system or process in place which covered daily equipment checks on their ambulance. This in relation to Regulation 12.
- The providers ambulance vehicle check list must include detail in relation as to what was checked and what was found. This in relation to Regulation 12.
- The provider must store medication in the original packaging with the patient information leaflet. This in relation to Regulation 12.
- The provider must have a policy for patients being transported to hospital with their own medication. This in relation to Regulation 12.
- The provider must carry infection prevention control audits, vehicle cleaning audits, vehicle deep cleaning audits and hand hygiene audits. This in relation to Regulation 12.
- The provider must provide staff with goggles and FFP3 facemasks as part of personal protective equipment. This in relation to Regulation 12.
- The provider must ensure call taker/ dispatchers and responders have attended accredited safeguarding training. This in relation to Regulation 13.
- The provider must have any key performance indicators which could be audited and reviewed to improve service delivery. This in relation to Regulation 17.
- The providers major incident plan must be tested by way of exercise or practically. This in relation to Regulation 17.
- The provider must review their patient record forms to reduce the risk confidential patient information being seen by people outside Gateshead Hatzola because of the existence of a carbonated copy of the PRF. This in relation to Regulation 17.
- The provider must have a system or process in place to review and update policies to ensure there was an identified author, a date it went live, a date for review and which version policy was. This in relation to Regulation 17.
- The providers PRFs must contain hospital handover information. This in relation to Regulation 17.

Action the provider SHOULD take to improve

- The provider should record when staff are required to attend refreshers courses.
- The provider should ensure call taker/ dispatchers and responders have a formal safeguarding qualification from an accredited training provider.
- The providers ambulance vehicle check list should include more detail in relation as to what was checked and what was found.
- The providers PRF should contain hospital handover information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; The providers patient record forms (PRF) did identify patient risk but did not include an overall patient risk assessment and what response to take in relation to that overall risk. The provider did not have a system or process in place which covered daily equipment checks on their ambulance. The providers ambulance vehicle check list did not include detail in relation as to what was checked and what was found. The provider did not store medication in the original packaging with the patient information leaflet. The provider did not have a policy for patients being transported to hospital with their own medication.

This section is primarily information for the provider

Requirement notices

The provider did not carry infection prevention control audits, vehicle cleaning audits, vehicle deep cleaning audits and hand hygiene audits.

The provider did not have a policy in relation to responders cleaning their own clothes to prevent the potential spread of infection.

The provider did not provide staff with goggles and FFP3 facemasks as part of personal protective equipment.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users. Volunteers had not attended accredited safeguarding training or had a formal safeguarding qualification from an accredited training provider.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.— (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

This section is primarily information for the provider

Requirement notices

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to be kept in relation to—

(i) persons employed in the carrying on of the regulated activity, and

(ii) the management of the regulated activity;

The provider did not have any key performance indicators which could be audited and reviewed to improve service delivery.

The providers major incident plan had not been tested by way of exercise or practically since the service had registered with CQC.

The providers PRFs had a carbonated copy left on a pad of PRFs when the original was removed.

The provider did not have a system or process in place to review and update policies to ensure there was an identified author, a date it went live, a date for review and which version policy was.

The providers PRF did not contain hospital handover information.

SENT BY EMAIL

CQC

Citygate

Gallowgate

Newcastle

NE1 4PA

Telephone: 03000 616161
Fax: 0300 616171

26 November 2020

Mr Michael Glickman

Gateshead Hatzola office

7 Bewick Road

Gateshead

NE8 4DP

Dear Mr Glickman,

Reference: Gateshead Hatzola Office 1-6646550017 post inspection action plan

Inspection reference: INS2-8067201181

Gateshead Hatzola Office was subject to a comprehensive inspection on 11 February 2020. The inspection report was published on 3 April 2020.

Following the inspection, the provider was required to submit an action plan in relation to requirement notices issued under Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment, Regulation 13 (Regulated Activities) Safeguarding service users from abuse and improper treatment and Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance HSCA 2008 which applied to both regulated activities carried out by the provider, which were, patient transport services and urgent and emergency care. The action plan was received by CQC on 17 April 2020.

Following the recent submission of evidence by you in respect of the post inspection action plan and following a review CQC are assured all the actions in the post inspection action plan have been finalised.

CQC now consider the action plan to be closed.

Yours Sincerely,

Michael Lillico CQC Inspector