Hanover House

Inspection report

78 Coombe Road
Kingston Upon Thames
Surrey
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Overall summary

The service was previously inspected on 27 July 2017, and again on 5 and 6 July 2018. At the latter inspection the rating for the practice was requires improvement overall. This rating applied to the safe, effective, responsive and well led domains. Caring was rated as good.

The report stated where the service must make improvements:

- Develop systems to ensure that the service can deliver local and national performance targets, including ensuring that sufficient clinical call handlers are available.
- Ensure that learning from incidents, safeguarding alerts and complaints is shared with all staff at the Hanover House site.
- Ensure that complaints are followed up in time and that actions are taken even where complainants are unavailable for follow up. To also ensure that complaints, and learning from them are shared with other healthcare providers where it is relevant to do so.
- Ensure that references are taken for all staff, including those working through employment agencies.

At this inspection the service is rated as **requires improvement** overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes. However, staff reported that the level of staffing was not sufficient
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. However, the service had not been able to meet nationally and locally agreed targets for service delivery.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. However, the service had not been able to assure itself that safe and effective care were being provided.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance.
- Ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in the service.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a managerial specialist advisor, and a second CQC inspector.

Background to Hanover House

Hanover House is the base hub for the 24-hour 111 service for South West London covering the boroughs of Wandsworth, Merton, Sutton, Kingston, Richmond and Croydon. The provider is Vocare who have responsibility for several 111, out of hours and urgent care services throughout the UK, and they have managed this service since September 2016. The service is co-located with the hub base for the out of hours service for these areas, although this service is delivered by a separate provider. The service serves a population of over 1.5 million patients.

Although the main hub site is in London, services are provided from two addresses. The first is 78 Coombe Road, Kingston-Upon-Thames, Surrey, KT2 7AZ. There is a call centre at this site which currently takes approximately 15% of calls and local management for the service is based at this centre. Further services are provided from a call centre at Crutes House, Fudan Way, Thornaby, Stockton-on-Tees, Cleveland, TS17 6EN, which manages 85% of all calls.

The service covers a large urban area, with large populations of both high and low deprivation. The population of South West London includes a large number of different nationalities and there are substantial populations of patients from ethnic minorities.

Although the provider is headquartered in Newcastle where many senior staff are based, there are clinical and operational leads within regions who have overall responsibility for the delivery of the service. There is a lead Pathways trainer for all operational staff. The operational teams are led by 11 team leaders in both the London and Stockton offices, each of whom have responsibility for a shift team.

The service manages between 27,000 and 32,000 calls per calendar month depending on the time of year. This is equivalent to approximately 1,000 calls per day.

The service is registered with the CQC to provide the regulated activity of Transport services, triage and medical advice provided remotely.

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services because:

- Staff we spoke with told us that there were insufficient health advisors and clinical staff at the service. We noted there were gaps in rotas that were not filled. For example, from 3 June until 26 August 2019, the service had not had more than 89% of its clinical sessions filled, and in one week it was as low as 70%.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- At any given time over 95% of staff had up-to-date safeguarding and safety training appropriate to their role. Where training was not complete staff were not permitted to work until such time that it had been completed. Staff we interviewed were all aware of how to identify and report concerns.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety. However, staffing at the service was not to complement, and staff reported that there were insufficient staff at the service to ensure that the volume of work could be managed in a safe way for patients.

- There were arrangements for planning and monitoring the number and mix of staff needed. However, there were significant rota gaps at the service. All but two of the clinical and administrative staff at the service told us that there was insufficient staffing at the service. Statistical information relating to performance supported this view.
- The provider told us that recruitment processes were continuous and that they had continued to recruit, mostly in the office in Stockton-on-Tees. They told us that they had a high turnover of staff and a high level of sickness absence of staff. Staff we spoke with reported that workloads had increased stress levels and that changes to their day to day role had made them unhappy.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Escalation systems were in place to manage people who experienced long waits.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Track record on safety

Requires improvement

Are services safe?

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the local NHS Ambulance service.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. Risk assessments and learning from events were shared with staff in folders, and staff were asked to sign the folders when they had read them.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. This included reviews with local out of hours providers.

Requires improvement

Are services effective?

We rated the service as requires improvement for providing effective services because:

- The service was not meeting local and national targets for the provision of effective care.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed. These were available on the intranet system and emailed to staff.
- Telephone assessments were carried out using a defined operating model which included processes for assessing patients' symptoms through a triage algorithm, with options including transferring the call to a clinician for further review.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients, including engaging with the local NHS acute trust to share information to identify, monitor and support those patients who frequently called the NHS 111 service and those who also frequently attended the hospital emergency department.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff assessed patients' pain where appropriate.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided. However, we noted that in a broad range of performance areas the service had not been delivering care in line with national and local targets.

- Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers. We saw the most recent results for the service (up to and including July 2019) which showed the provider was not meeting a number of the national performance indicators:
  - The service had not met its key performance indicator for the number of abandoned calls. Since the beginning of 2019 the number of abandoned calls had only been under 4% once (compared to a KPI sliding scale target of 1% to 5%), and in February 2019 was over 8%.
  - The percentage of calls that were warm transferred (calls which are directly passed from a health adviser to a clinician) in line with guidelines was between 13% and 53% in the last year. The target a sliding scale between 95% and 98%.
  - The service was below the 98% target for all three of its timed call-back targets, and for the second most urgent call back times, was only achieving between 49% and 73%.
- Where the service was not meeting the target, the provider had put actions in place to improve performance in this area. However, the actions that they had put in place had not yielded an improvement in performance at the time of our inspection.
- The service made improvements through the use of completed audits. There was clear evidence of action to resolve concerns and improve quality. The service had systems in place to meet the national quality requirements for auditing at least 1% of clinical patient contacts. The service had scored 100% in all five of its audit key performance indicators for the last seven months. Staff reported that feedback was helpful and well structured.
- The service shared wider audits with the local out of hours provider.

Effective staffing

Requires improvement

Are services effective?

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Staff told us that regular one to one meetings were in place from their managers, although staff in London reported that this was less often as their managers were not always based in the London office.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. However, the service was not meeting agreed timescale targets for which clinical call backs should be made..
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a clear approach through the services quality audit programme, for supporting and managing staff when their performance was poor or variable. Measures included direct staff feedback, mentoring and supervision.
- The service had team meetings in place and had implemented “huddle” meetings where these were not possible.

Coordinating care and treatment

Staff worked together, and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GPs so that the GP was aware of the need for further action. There were established pathways for staff to follow to ensure callers were referred to other services for support as required.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- Issues with the Directory of Services were resolved in a timely manner. We saw that changes were made where relevant, including the prioritising of mental health services where indicated.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- The service identified patients who may needed extra support such as through alerts on the computer system.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs including training, awareness seminars and bulletins for specific staff groups.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs by providing access to local and regional out of hours bases.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service, for example there were alerts about a person being on the end of life pathway. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients could access care and treatment at a time to suit them. The NHS 111 service operated 24 hours a day.
- Patients could access 111 services electronically rather than by telephone. This service worked to similar timescales as the telephone-based service. This service enabled those patients who were unable to converse with a call handler to access the service. Translation services were also available where required.
- Patients had not always received timely access to an initial assessment and referral. However, the service had detailed audits and review procedures where actions to address poor performance were addressed. We saw the most recent local and national key performance indicator (KPI) results for the service for the 2018/19 financial year which showed the provider was not meeting the following indicators:
    - The percentage of calls answered within 60 seconds was between 72% and 87% for each of the 12 months prior to the inspection (national target 95%, KPI 95%)
    - The proportion of calls where the person was called back on 10 minutes ranged between 53% and 65% (national target 50%, KPI 50%).
- Where the service was not meeting the target, the provider was aware of these areas and we saw evidence that attempts were being made to address them through close working with the service commissioner. Measures included advanced monitoring and reporting of performance data, recruitment of staff and increased used of call handling networking capabilities across the providers network.
- Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We reviewed a sample of the complaints received by the service and found that all were satisfactorily handled in a timely way. We saw that the electronic database had a record of every step of the process of handling the complaint from receipt through to resolution. Letters of apology detailing the findings of the investigations were clear and sufficiently detailed.
- Complaints were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway if relevant. For example, where shared care learning required involvement from the ambulance service or the out of hours provider, these organisations were involved in responding to the complaint.
- The service learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. We saw learning from complaints and other patient feedback being shared through, the service's internal bulletin, and through management of staff performance.

Requires improvement

Are services well-led?

We rated the service as requires improvement for leadership because:

- The service did not have systems in place to assure itself that national and local targets could be met, and to ensure that there was adequate staffing.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- Managers at the services were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them and had developed action plans so that these areas might be addressed.
- Staff at both sites told us that leaders at all levels were visible and approachable, and that they worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. However, issues that required improvement and had been highlighted in previous CQC reports remained unaddressed.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. However, previous CQC reports had highlighted staffing and meeting national outcomes, as issues that the provider must address. These issues remained areas to address for the provider at this inspection.
- The provider had regular contract meetings with the commissioner to discuss performance issues and where improvements could be made. The service was actively engaged in contract monitoring activity with commissioners and had made a number of commitments to address performance issues including National Quality Requirement statistics.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them, although some staff in the London office said that they were not consulted before changes were made. They reported that they did not feel involved in the organisations' vision and values.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.

Culture

The services had a culture of high-quality sustainable care. However, low staffing levels and staff not being involved in decision making had impacted upon this.

- Most staff felt respected, supported and valued, and said that they were proud to work for the service. However, some staff reported that senior staff at the organisation did not treat all staff equally.
- Staff reported that they did not feel that the provider had yet addressed shortfalls in staffing at the service.
- Staff at the London hub told us that work had been moved from them to the Crutes House site, and changes had been made to their terms and conditions without consultation.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and

career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams at the Crutes House site, but staff at Hanover House said that changes were made without consultation.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators, although targets were not consistently being met. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The

Requires improvement

Are services well-led?

provider, in conjunction with the out of hours provider in the area, met regularly with patient groups across the CCGs for which it had responsibility and shared information with them as relevant.

- Staff could describe to us the systems in place to give feedback, including written through feedback forms, staff surveys and verbal feedback through internal meetings and service delivery managers. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation work.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The service was not delivering service in line with standards defined by national quality requirements and other local and national guidelines. • The service did not have systems in place to deliver sustained improvement. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • Staff told us that there were insufficient numbers of both health advisers and clinical call handlers at the service. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.