GP Care UK Limited

Stroud General Hospital

Inspection report

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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 to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

This service had not been previously inspected. We rated it as requires improvement because:

- There was no formal process recorded for staff working under SLA to escalate medical emergencies. There was also no formal process recorded for the management of medicines used in the service.
- Not all staff working under SLA had received a regular appraisal. The service did not routinely use all information from surgical safety checklists to assure itself services were carried out safely.
- The service did not monitor post-operative infections effectively.
- Not all audits set out in the service's audit plan had been completed.
- There was no formal review process for SLAs held by the service.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in most key skills, they understood how to protect patients from abuse. Staff assessed risks to patients, acted on them and kept good care records. Staff knew how to report patient safety incidents.
- Staff provided good care and treatment and gave patients enough to eat and drink. Staff worked well together and managed patients' post-operative pain well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable and supported staff to develop their skills. The service had a vision for what it wanted to achieve which was focused on sustainability of services and aligned to local plans within the wider health economy. Staff at all levels were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	This service has not been previously inspected. We rated it as requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Stroud General Hospital

GP Care UK Limited is a social enterprise providing specialist medical services in the South-West of England. The provider was originally founded by, and are still owned by, over 100 local GPs. GP Care UK Limited has multiple contracts with NHS commissioners offering NHS patients access to diagnostic, outpatient and ancillary healthcare services at community locations. The service treats over 20,000 patients a year mainly in Bristol, North Somerset, South Gloucestershire, Swindon, Gloucestershire and Devon. Care and treatment are provided at a number of clinic locations within these areas including GP practices and hospitals.

The service used facilities at Stroud General Hospital and had a registered location in the same name which is operated by GP Care UK. The service was registered on 29 January 2019 and provides minor day case urology surgery as part of a wider Gloucestershire urology pathway.

The service is registered for the regulated activity of:

- Surgical procedures.

Services provided under contract from NHS clinical commissioning groups include:

- Minor day case surgical services for urology patients.

We have not inspected this service before.

The service holds one day case theatre session per month seeing approximately six patients. The service also provides occasional additional day case theatre sessions to f accommodate additional demand for the service.

Between April 2021 and March 2022; the service saw 68 patients and carried out 57 circumcisions and 11 other minor surgical procedures.

The service has a manager who was going through The Care Quality Commission registered manager application process at the time of our inspection.

How we carried out this inspection

The team that inspected this location comprised of one CQC inspector and a specialist advisor with expertise in surgery and outpatients. We spoke with three members of staff (working under a service level agreement) including the operating consultant. We also spoke with two managers directly employed the service, two patients on site and held a telephone interview with one member of staff also directly employed by the service. We also observed interactions with patients throughout the clinic. We reviewed documents and records kept by the provider and inspected the surgical theatre.

There were no special reviews or investigations of the location ongoing by the CQC at any time during the 12 months before this inspection.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service MUST make sure there is a suitable escalation process to deal with medical emergencies in place at the host site. **Regulation 12 (2) (b)**
- The service MUST establish a way to record and report all suspected and confirmed post-surgical infections. **Regulation 12 (2) (h)**
- The service MUST ensure medicines administered under any third-party agreements are handled, administered and recorded safely and in line with legislation. **Regulation 12 (2) (g)**
- The service MUST make sure there is a formal process for managing and monitoring any service level agreements (SLA) the service has with any third parties. **Regulation 17 (2) (b)**

Action the service SHOULD take to improve:

- The service should ensure that it has oversight of any surgical safety audits including the World Health Organisation safer surgery checklist.
- The service should review all available infection prevention control data including audits carried out by organisations under service level agreements.
- The service should make sure it carries out all planned audits as defined in the company clinical audit plan.
- The service should ensure all staff working for the service either directly or under service level agreement, have received an appraisal.
- The service should be able to demonstrate evidence of DBS checks (such as certificate numbers) for all staff working in the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

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

Are Surgery safe?

Requires Improvement

We have not rated safe before. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff it directly employed.

Nursing staff received and kept up to date with their mandatory training. We looked at staff training records for staff employed directly by the service and for staff employed under a service level agreement (SLA). We saw 94% staff working under an SLA had completed their mandatory training. For the two staff directly employed by the service both had completed all their mandatory training.

The mandatory training for nursing staff was comprehensive and met the needs of patients and staff. The service listed 13 subjects as mandatory including manual handling, mental capacity and safeguarding adults and children training and requirements varied between the two staff according to their role.

We also reviewed mandatory training records for both consultants working in the service. At the time of the inspection these records showed both consultants were not compliant with manual handling or conflict management training, with no training data recorded. Additionally, one consultant was not up to date with information governance training and domestic violence training. The other consultant was not up to date with equality and diversity training. Following the inspection, managers submitted further training data to show all mandatory training subjects had now been completed.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. During inspection we reviewed training and personnel folders and, spoke to staff. Clinical staff we spoke with had a good understanding of all four areas and had told us they received further training from their main contracted employment.

Managers monitored mandatory training and alerted staff when they needed to update their training. Most staff working in the service were subcontracted from another healthcare provider. Every six months, managers shared training data on these staff so the service could ensure staff were up to date with their mandatory training and challenge any areas of poorer compliance if necessary.

The service had a policy for sepsis management and were staff aware of it. Staff received annual training on sepsis management; including the use of sepsis screening tools and use of sepsis care bundles. Training records showed all staff were up to date with this training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The service had provided training to staff about safeguarding vulnerable adults and children from abuse. We reviewed staff files and the locations training records, and we saw clinical staff had received level two training in safeguarding children and adults, which was in line with national guidance.

Training data was shared between the service and the host hospital. At the time of our inspection 93% of staff working for the service under the service level agreement (SLA) had competed level two adults and child safeguarding training or higher. Both staff members employed directly had completed safeguarding adults and children level two training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Most of the staff we spoke to were clear who the service's safeguarding lead was and who they should escalate concerns to. We reviewed the service's safeguarding policy which detailed actions for staff if they had a concern.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service did not use all systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The theatre and recovery areas were clean and had suitable furnishings which were clean and well-maintained, and we saw daily cleaning check sheets to confirm this. We also saw an annual environmental action plan undertaken by the host hospital which was shared with the service for oversight.

The service generally performed well for cleanliness. Cleaning records showed good compliance with no omissions on the two daily cleaning schedules we reviewed. However, overall infection prevention and control audits including hand hygiene audits were undertaken by contracted staff from another healthcare provider. These audits and actions were not routinely shared with the service. Following the inspection, we saw an environmental audit which had been carried out in April 2021 by the service although it was unclear what actions had been taken, partly because the service was not running because of COVID-19 at the time of the audit.

Staff used records to identify how well the service prevented infections. Reviews of the whole minor surgery service (of which the service was one part) included an annual overarching review of post-surgery infection rates and abnormal histology results. However, there had been no instances of post-surgical infections in the service. Managers were assured infections would be picked up through the post-operative follow up process and would be investigated individually or by

exception. However, staff reported that patients were frequently referred to their GP with any suspected signs of infection, but the service did not monitor this routinely. Managers explained patients with suspected infections were given a four week follow up call, but because none of these calls had been arranged, the service had taken assurance there had been no suspected or confirmed infections. Following the inspection, managers audited patients who had used the service in the last 12 months and found one patient had visited their GP with an infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw correct levels of PPE was used during clinic sessions by all staff.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw clinical equipment was cleaned at the end of each clinic session and documented records kept.

Clinical staff worked effectively to prevent, identify and treat surgical site infections. Clinical staff we spoke with knew how to identify and manage patients with severe infections, for example sepsis. Clinical staff could describe the signs of symptoms of sepsis and showed us the assessment bundle they would use if sepsis was suspected. The service reported no incidents of confirmed or suspected sepsis since registration in January 2019.

The service did not routinely screen new admissions for *Methicillin-resistant Staphylococcus aureus* (MRSA). However, specific questions were asked as part of the pre-operative checklist around historical positive MRSA tests. If a patient had tested positive, they were referred back to the consultant for follow up and further tests if necessary.

The service managed and decontaminated reusable medical devices in line with national guidance such as the Department of Health Technical Memorandum on decontamination. Sterile surgical equipment was provided by a third-party supplier, but we saw staff assessing all equipment prior to use. Staff described what they would do should a problem be found with any of the kit.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. All call bells had been tested in line with the host hospital's maintenance policy.

The design of the environment followed national guidance. The recovery ward was large with plenty of room for social distancing if necessary.

Staff working under contract through a service level agreement, carried out daily safety checks of specialist equipment. We saw evidence to demonstrate some clinical equipment calibration had taken place including resuscitation equipment.

The service had enough suitable equipment to help them to safely care for patients. The service kept adequate stocks of sterile surgical equipment on site to ensure there were no delays should equipment need to be replaced prior to surgery.

Staff disposed of clinical waste safely in line with the service level agreement between the host site and the service.

Facilities and surgical equipment including resuscitation and anaesthetic equipment were available and fit for purpose and were checked in line with professional guidance. We saw all daily checks of resuscitation equipment had been consistently carried out without any missing entries.

Requires Improvement

Surgery

Instruments, equipment and implants complied with Medicines and Healthcare products Regulatory Agency (MHRA) requirements and there were processes for providing feedback on product failure to the appropriate regulatory authority. As part of a governance structure review, the service introduced a system for the oversight and management of information from external sources such as MHRA alerts.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised some risks. Staff identified and quickly acted upon patients at risk of deterioration. However, there was no written record of actions staff would take in the event of an emergency.

Staff working under a service level agreement (SLA) had access to a nationally recognised tool to identify deteriorating patients and could tell us how scores would be escalated using the National Early Warning System (NEWS). However, there had been no instances where it had been necessary to us this tool.

Staff employed by GP care UK completed risk assessments for each patient prior to admission using a standardised tool. A standard pre-operative checklist was used to gather as much information about the patient which included a full medical history as well as collecting information about DVT risk, mobility and suitability for surgery under local anaesthetic.

All clinical staff knew about and dealt with any specific risk issues. Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Medicines and equipment to deal with medical emergencies was provided by the service hosting the clinic.

All staff shared key information to keep patients safe when handing over their care to others. Clinicians working under an SLA made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Shift changes and handovers included all necessary key information to keep patients safe. We saw the morning safety huddle which included discussion around all the patients for the day including any safety concerns.

The service did not ensure compliance with the 5 steps to safer surgery, World Health Organisation (WHO) surgical checklist. The checklist was completed and audited by staff contracted from another healthcare provider, but the outcomes of the audits were not routinely shared.

The service ensured there was access to consultant medical input. The entire patient pathway, from referral to surgery, was reviewed by the operating consultant who remained onsite until the last patient from the list had been discharged.

At any given time, at least one member of recovery staff was trained and certified in Advanced Life Support (ALS). Both operating consultants were ALS trained and all clinical staff were trained in Immediate life support (ILS).

There was evidence a sepsis care bundle for the management patients with presumed/confirmed sepsis was available for staff to use although the service had never had any suspected or confirmed cases of sepsis.

There was an escalation policy for patients with presumed or confirmed sepsis. Staff explained all patients would receive prompt assessment when escalated to multi-professional team. For example: Critical Outreach Team. The service had no case of confirmed or suspected sepsis since opening in January 2019.

Requires Improvement

Surgery

The service ensured there was appropriate 24-hour emergency call or hotline arrangements in place following discharge. Patients were instructed to contact their GP in the first instance but also have a direct phone number for the GP care UK call centre. Messages were passed to the clinical matron or nurse to follow up with the patients.

The service did not have an admission or acceptance policy. However, each patient referred to the service from their GP was individually assessed by one of two consultant surgeons who also worked within local NHS services. Where patients were deemed unsuitable for the community surgery service, they were directly referred into an appropriate NHS service in the local area.

There were no protocols within the SLA held by the service and the host hospital for the transfer of people using services to the NHS in the event of complications from surgery. The host site's resuscitation policy stated any processes for dealing with medical emergencies were to be determined locally but the license and contract provided by the service did not contain any further details. However, posters were displayed to remind staff of actions to take in a medical emergency.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. All nursing staff were supplied under a service level agreement (SLA) with the hosting hospital.

Managers from the host hospital accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. This model was also shared with the service for oversight. Guidance on theatre staffing levels was also followed as set out by recognised professional bodies such as the Royal College of Surgeons.

The ward manager could adjust staffing levels daily according to the needs of patients. At the time of our inspection we saw the number of nurses and healthcare assistants matched the planned numbers.

The only staff involved in the patient pathway who were directly employed by the service were one pre-operative nurse and one clinical matron.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The two consultant surgeons who worked in the service were provided through a subcontracted external agency.

At the time of our inspection, the medical staff matched the planned number.

Managers made sure all medical staff supplied by the agency had a full induction to the service before they started work. All current medical staff had received an induction.

All surgery carried out by the service was consultant delivered and led.

Requires Improvement

Surgery

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care, but there was no evidence of any routine audit of records for this service.

Patient notes were comprehensive, and all staff could access them easily. Individual care records were written and managed in a way that kept patients safe. The three care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Records were stored securely and arrived at the surgical unit in paper format in a locked box.

The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance if the provider ceased trading.

We reviewed three care records and saw all relevant information was recorded correctly including any risk assessments such as falls and deep vein thrombosis (DVT) risk.

Records audits were not routinely undertaken by the service. However, every paper document was scanned onto the electronic system by a clerical officer who escalated any missing or blank documents. Managers explained there was a piece of work underway to look at documentation standards as part of an overarching governance review.

The service ensured that an appropriate pre op assessment was recorded. The service had a pre-operative nurse who carried out all assessments via telephone. They followed a standardised tool which took account of the patient's medical history plus risk factors such as deep vein thrombosis (DVT), falls and mobility.

Discharge summaries were given to patients when they were discharged from the service. A copy was also sent to the GP to ensure continuity of care within the community.

Medicines

The service used systems and processes to safely store medicines but had no evidence to show medicines used in surgery were administered, handled or recorded safely and there was no audit of records for this service.

Staff working under a service level agreement (SLA) followed systems and processes to prescribe and administer medicines safely. However, documents supplied did not contain any details about who provided medicines or how their safe handling, administering, storage or recording was to be managed or monitored.

Staff completed medicines records accurately and kept them up to date, but records were not routinely audited.

We reviewed three medicines records and saw all information about medicines used in the procedure were recorded along with any patient allergies.

Staff working under an SLA followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Patients were not routinely given medicines to take away but were instead given advice regarding pain relief. Further advice was given to contact the GP for stronger pain relief if needed.

The service did not prescribe controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence).

Requires Improvement

Surgery

Medicines used for surgery such as local anaesthesia were supplied and monitored under the service level agreement (SLA) with the hosting hospital. However, we were not supplied with details of the types and amounts of medicines provided or of how the service was assured medicines were handled and administered safely.

Incidents

The service managed patient safety incidents well. Incidents were reported by pathway for the region and could be divided by individual clinic location. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

All staff raised concerns and reported incidents and near misses in line with service policy. All staff we spoke to were clear on what types on incidents need to be reported and why. Staff were clear on which healthcare provider they reported incidents to. However, managers from both the service and the host hospital told us they would share information if an incident came through which affected the other service.

There were adequate systems at location level 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. An annual report of all incidents was undertaken yearly. We reviewed the 2020/21 report which showed there were no serious incidents (including unexpected or avoidable deaths or injury) between April 2020 and March 2021. Of the 228 incidents reported 47 were related to urology services in Gloucestershire (of which the service was one of several locations). Of these, 27 were adverse incidents and 20 were near miss incidents but none related to the service. Additionally, there were no incidents attributed to the service recorded in the 12 months prior to our inspection.

All staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The service encouraged a culture of openness and honesty.

When there were unexpected or unintended safety incidents the service would give affected people reasonable support, truthful information and a verbal and written apology. Managers explained they would keep written records of verbal interactions as well as written correspondence. There had been no incidents in the service where duty of candour had needed to be applied.

All staff working in the service would receive feedback from investigation of incidents, both internal and external to the service. We reviewed the quarterly incident report for the entire Gloucestershire urology pathway which contained details of incidents and shared leaning from other locations on the pathway. Staff employed by GP Care UK were aware of this report and had seen it.

There was evidence that changes had been made as a result of feedback to the provider, elsewhere on the urology pathway, such as updating satellite navigation directions to help patients find locations easily.

Managers employed by GP care UK were familiar with criteria within the Serious Incident Framework which describes the general circumstance in which providers and commissioners should expect serious incidents to be reported. However, no incidents had been reported for the service since its registration in January 2019.

Requires Improvement

Surgery

Are Surgery effective?

Requires Improvement

We have not rated effective before. We rated it as requires improvement.

Evidence-based care and treatment

The service provided most care and treatment based on national guidance and evidence-based practice but did not use all information available to monitor or assess post-surgery infections. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

All staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.

The service ensured that other national operating procedures reflected professional guidance. For example, sepsis screening and management was done effectively and in line with National guidance such as NICE guidance. All staff were aware of the signs and symptoms of sepsis and showed us the host hospital's sepsis 6 care bundle which they would use to asses any suspected patients with sepsis.

The service ensured that care was managed in accordance with NICE guidelines. For example, the service followed Quality Statement 49 on surgical site infections. However, the service did not routinely collect data on patients referred to their GP with a suspected infection. Following the inspection, the service audited all post-operative calls and found one patient had been to their GP with a confirmed infection.

Standard operating procedures were in place and in line with best practice. For example, we saw procedures for the urology surgical service, booking of patients into clinics and post consultation referral pathways.

Nutrition and Hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff working under a service level agreement (SLA) made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

Staff working under an SLA had access to fluid and nutrition charts where needed. We reviewed three records which showed fluid were included but not completed as this was not a requirement for the type of surgery performed.

The service could ensure that following surgery people were given effective management of nausea and vomiting. However, staff working under and SLA explained this was very rare for the type of procedure undertaken but told us they would get the consultant to review the patient prior to discharge.

Requires Improvement

Surgery

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave appropriate advice. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

All staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. As part of pre-operative assessments, patients were advised of the amount and type of pain relief they would need post operatively. Staff recorded pain scores accurately in care records.

Patients in recovery post-surgery still experienced the effects of the local anaesthesia used for the procedure. Staff working under a service level agreement (SLA) made sure patients understood this would wear off and checked they had pain relief available to self-care at home.

The service ensured that following surgery, where patients felt their pain was greater than expected, they had access to their own GP or the GP Care UK call centre. Questions received by the call centre were escalated to and followed up by the clinical matron or pre op nurse.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. A clinical audit schedule supplied showed all services audited infection prevention and control, clinical records and compliance with best practice guidelines. However, none of these audits were supplied for the service at although we saw discussions around one of the best practice proposed audits in the December 2021 clinical audit meeting minutes.

Outcomes that were collected for patients were positive, consistent and met expectations, such as national standards. Standard operating procedures were in place and in line with best practice. For example, we saw procedures for the urology service, booking of patients into clinics and post consultation referral pathways. However, the service did not use all information available to monitor post-surgery infection rates.

The service used information about care and treatment to make improvements. For example, they worked with service commissioners to redesign the specifications of the service following analysis of data and performance.

The service regularly reviewed the effectiveness of care and treatment through some local audits. Managers used information from the audits to improve care and treatment. The service undertook monthly performance reviews to analysis the effectiveness of the service. This included reviews on key performance indicators including trends and analysis of performance and RAG (Red, Amber and Green) ratings as a way of indicating quality improvement areas. They utilised data from internal and external information including key performance indicators.

Competent staff

The service made sure staff they directly employed were competent for their roles. However, there were gaps in some subcontracted staff records. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff were appropriately qualified. The service had an induction programme for all newly appointed staff.

Requires Improvement

Surgery

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection all nursing staff employed by GP care UK in the service had received an annual appraisal. However, one of the two consultants working under practising privileges had not had an appraisal since January 2021, partly due to COVID-19 measure in place at the time.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Both nurses employed by GP care UK had received clinical supervision sessions within the last 12 months.

Relevant professionals (medical and nursing) were registered with the appropriate professional council such as the General Medical Council and were, where appropriate, up to date with revalidation. Registrations were reviewed annually and information about staff employed under a service level agreement was shared with the service.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff electronically sent confirmation to confirm they had read any meeting minutes.

Managers identified any training needs staff employed by GP Care had.

There was a system to record when clinical staff who undertook mandatory training with their main employer completed and updated this training. The service employed staff from two external organisations. As part of the service level agreement with one of the organisations (the host hospital) managers shared training and appraisal information every six months.

Staff employed by GP Care UK were given time and opportunity to develop their skills and knowledge. They provided protected time and training to meet their mandatory training programme. Up to date records of skills, qualifications and training were maintained.

Staff employed by GP Care UK had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were encouraged and given opportunities to develop. For example, through the institute of leadership and management.

Managers from the host hospital made sure staff received any specialist training for their role and shared this information with managers from the service. Competencies were in place for clinical and non-clinical staff.

Managers monitored performance of staff employed by GP Care UK and identified areas or poor performance promptly and supported staff to improve. The staff working under a service level agreement had their performance monitored by their line managers, but information or concerns around performance were shared with the service's managers.

The service ensured that all staff only carried out surgery that they were skilled, competent and experienced to perform. Consultant surgeons were supplied though a dedicated agency and had to provide evidence of their work prior to appointment in the service.

There were arrangements to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty. The host hospital shared information with the service about revalidation and fitness to practice concerns for staff employed under a service level agreement. For staff directly employed, manager shared information with the host trust although there had been no instances where this had occurred since the service was registered in January 2019.

Requires Improvement

Surgery

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred to and communicated effectively with other services when appropriate. For example, patients were given copies of their discharge summaries which were also sent to the patient's GP.

The service ensured access to medical consultant was available during the theatre session and all team members were aware of who had overall responsibility for each patient's care.

There was evidence of interagency working when required. For example, patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

Data for the service showed that a patient's own GP was provided with a summary of care and treatment within two days of being seen. For the urology clinic we saw the service consistently achieved a 100% completion rate which was more than the target rate of 96%.

Seven-day services

We could not assess this key question as services were only commissioned for six patients on one theatre session per month.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Where appropriate, staff gave people advice so they could self-care.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.

Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.

Requires Improvement

Surgery

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff supported patients to make decisions. Clinicians we spoke to told us, where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Staff made sure patients consented to treatment based on all the information available. Staff used information from professional bodies, such as the British Association of Urological Surgeons, to begin the process of informed consent.

Staff clearly recorded consent in the patients' records. We reviewed three sets of records and saw consent for treatment had been recorded and signed in all.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005 they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

There were processes to aide translation during the consent process. Translators were accessible and were able to join pre and pot operative calls. Where patient shad hearing loss, a person to act for them was nominated at the urology outpatient clinic before the pre-operative process began.

Are Surgery caring?

Good

We have not rated caring before. 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.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All staff we saw introduced themselves and were polite and courteous.

The service sought feedback on the quality of care it provided. The latest results of which showed that between October 2021 and December 2021, across the whole Gloucestershire urology pathway, 99% of respondents would recommend the service.

Patients said staff treated them well and with kindness. We spoke with three patients during our inspection. Patients told us staff were wonderful and polite and showed sensitivity towards them. We saw staff interacting with patients in a calm unhurried manor and saw they treated patients kindly.

Staff followed policy to keep patient care and treatment confidential. We observed staff interactions with patients during clinical procedures. Staff we observed gave patients enough time to discuss procedures and concerns and were very kind and caring and made sure conversations about treatment took place in private consultation rooms.

Requires Improvement

Surgery

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They displayed an understanding and non-judgmental attitude to all patients.

Staff responded to patients who might be frightened or confused. Staff employed by GP care UK explained they asked patient to describe what they understood they were having done to make sure there was no confusion. Staff told us is necessary patients could bring a companion if they were especially anxious about any aspect of their care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Private rooms were available should patients wish to discuss sensitive matters.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw evidence that staff used (where possible) the patient's own preferred methods. Easy read, braille and materials in other languages were also available.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Latest feedback comments for the whole Gloucestershire urology pathway included:

"Very happy all round with the service I've been given"

"Could not see room for improvement. Very professional"

"Overall, very happy with service"

We also saw where negative feedback had been received, the service took action to make improvements and had a rolling action log.

Staff supported patients to make informed or advanced decisions about their care. Where patients needed to be referred on to a different service, this was fully discussed with the patient and their families and loved ones.

Are Surgery responsive?

Requires Improvement

Surgery

Good

We have not rated responsive before. 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.

Managers planned and organised services, so they met the needs of the local population. The service understood the needs of their patients and improved services in response to those needs. For example, following feedback on quarterly patient surveys, the service reviewed and updated location maps and directions across the whole Gloucestershire urology pathway. They also reviewed the locations in Gloucestershire following poor patient feedback regarding facilities at these locations. This resulted in changing locations so standards of facilities were of good quality.

Facilities and premises were appropriate for the services being delivered. The facility and premises which hosted the day case surgery was appropriate for the services delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. Reasonable adjustments had been made so that people in vulnerable circumstances or those with sensory disadvantages such as those who required an interpreter could access and use services on an equal basis to others. A text message service was used to remind patients of booked appointments.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Training records showed and we saw that both GP Care staff members had received this training.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Reasonable adjustments had been made so that people in vulnerable circumstances or those with sensory disadvantages such as those who required an interpreter could access and use services on an equal basis to others.

The service had information leaflets available in languages spoken by the patients and the local community.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed including for telephone pre ad post-operative assessments.

Patients were given a choice of food and drink to meet their cultural and religious preferences although staff explained this was usually not necessary for the day case surgery carried out as patients were not in the hospital for very long.

Staff had access to communication aids to help patients become partners in their care and treatment. For example, pain scales were used to gauge post-operative pain.

Requires Improvement

Surgery

Access and flow

People could access the service when they needed it and received the right care.

Managers employed by GP Care UK monitored waiting times and made sure patients could access services when needed.

Patients had timely access to initial assessment, test results, diagnosis and treatment.At the time of our inspection, there were 54 patients currently waiting for surgery, which equated to a five month wait time. The service was not monitored against any referral to treatment target such as the 18-week pathway, although the decision to do this was determined by the local commissioners.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Waiting times, delays and cancellations were minimal and managed appropriately.

Managers and staff worked to make sure patients did not stay longer than they needed to. Clinics had staggered appointment times to minimise patient waits in clinic.

Managers monitored and took action to minimise missed appointments. In the 12 months leading up to our inspection, the service had one non-attender (DNA).

Managers ensured that patients who did not attend appointments were contacted and reasons recorded.

Managers worked to keep the number of cancelled appointments and operations to a minimum. When patients had their appointments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We saw that between April 2021 and April 2022, the service cancelled 34 operations. Of those cancellations, 15 were because of cancelled clinics. The other 19 were due to patient preference or patient illness.

The service demonstrated patients received appointments within set timescales. The service had one key performance indicator which was to perform six procedures per month. This had been consistently achieved over the past 12 months and was reported on to the local commissioners for the service.

Managers and staff worked to make sure that they started discharge planning as early as possible. Patients were kept in recovery post procedure for at least 30 minutes. Once ready for discharge, they were given all necessary information including advice on pain relief and signs of infection to look for.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Although no patients we spoke with felt the need to do so.

The service clearly displayed information about how to raise a concern in patient areas and was available to patients. Staff treated patients who made complaints compassionately.

Requires Improvement

Surgery

Staff understood the policy on complaints and knew how to handle them. Staff actively encouraged use of the complaint procedure.

Managers investigated complaints and identified themes. The service had a complaint policy and process to manage complaints about the service. We reviewed the complaints policy, however the service had received no complaints since its registration in January 2019, so we could not review any responses.

Staff knew how to acknowledge complaints and the service's policy stated that patients would receive feedback from managers after the investigation into their complaint. The service would inform patients of any further action that may be available to them should they not be satisfied with the response to their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service learned lessons from individual concerns, complaints and from analysis of trends across the whole Gloucestershire urology pathway. It acted as a result to improve the quality of care. This included an annual review of patient and contractor complaints. For 2020/21 across all the provider pathways, 28 complaints were received, of which 22 were from patients or their carers which relates to less than 0.17% of the total number of patients seen during this period. Of these complaints, five were about the Gloucestershire urology pathway. No complaints had been received about the service.

Staff could give examples of how they used patient feedback to improve daily practice. We saw, as a result of complaints, the service made improvements. For example, they developed in-depth patient guides for different services provided.

Are Surgery well-led?

Requires Improvement

We have not rated well led before. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge, experience and integrity that they needed. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The service had a realistic strategy and supporting business plans to achieve its goals.

Requires Improvement

Surgery

There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. The mission statement for the service was: to reduce hospital waiting lists and patient waiting times by increasing the availability of rapid access specialist diagnostic, assessment and treatment services in local health care communities of which the service was one part.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. The service had recently re-developed its vision, values and strategy jointly with staff.

Staff we spoke to who were employed by GP Care UK were aware of and understood the vision, values and strategy and their role in achieving them.

Progress against delivery of the strategy and local plans was monitored and reviewed. The provider undertook a shareholder's survey every three years to ensure their views formed part of ongoing strategy reviews.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt respected, supported and valued. They were proud to work for the service.

Staff told us they were able to raise issues, and this was acted on.

Leaders, managers and staff acted on behaviour and performance consistent with the vision and values. Across the whole Gloucestershire urology pathway, openness, honesty and transparency were demonstrated when responding to incidents and complaints. The service was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed. The service had access to a Freedom to Speak Up Guardian.

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 development and evaluation of their clinical work. However, we saw one consultant had not had an appraisal since February 2021, partly due to COVID-19 restrictions in place at the time.

The service had core expected values and behaviours for the organisation and their staff. These, along with the services objectives and vision, were incorporated into performance reviews. The organisation's values were rated for each individual staff member to identify areas of development.

There was a strong emphasis on the safety and well-being of all staff. For example, the service had provided staff with wellbeing and mindfulness sessions. The service also had four trained mental health first aiders.

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 we spoke with felt they were treated equally.

Staff had received unconscious bias training to enable them to identify any bias which may affect the way patients are treated.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality sustainable services. Structures, processes and systems to support good governance and management had been recently reviewed and relaunched.

Levels of governance and management functioned effectively and interacted with each other appropriately. The service utilised a governance dashboard for oversight and assurance of risks, clinical governance, key performance indicators and compliance with regulations, although this was at provider level. The service inspected made up part of the overall Gloucestershire urology pathway.

The governance and management of partnerships and joint working arrangements promoted interactive and co-ordinated person-centred care. Staff were clear on their roles and accountabilities.

Leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. As part of these processes they undertook visits and audits at the host location to ensure the location and their staff were complying with legal requirements. We saw an up to date risk assessments had been undertaken January 2022 but was kept live to accommodate regular updates in practice from Public Heath England.

The provider undertook an annual audit of their accounts with external auditors. This went above contractual requirements.

It had been identified by senior management that the term clinical governance was not understood by all staff, including non-clinical staff. Staff had reported they did not understand how it applied to non-clinical roles. As part of a governance structure review, clinical governance had been re-launched as Quality improvement and patient safety to make it relevant to all roles, not just clinical.

There were no governance procedures for managing and monitoring any service level agreements (SLAs) the service had with third parties. At the time of our inspection, the current SLA had not been reviewed. Managers explained that because of the uncomplicated nature of the patient pathway, a review had not been necessary as there had been no changes or modification to the pathway or service. The SLA provided showed the service had a licence for the provision of the surgical services it carried out and a standard contract with local commissioners. However, details around medical emergencies and medicines management were not covered in any document provided. Following our inspection, the service provided an updated contract which included a drafting review schedule.

The service was not monitored against any standard NHS pathway referral to treatment targets such as the 18-week pathway, although the decision to do this was determined by the local commissioners and not the service itself.

Requires Improvement

Surgery

Management of risk, issues and performance

Leaders and teams used most systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes. There was an overarching process to identify, understand, monitor and address current and future risks.

There was a provider wide systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. However, not all planned audits had been undertaken for the service. Clinical audit that had taken place, had a positive impact on quality of care and outcomes for patients. There was evidence of action to change services to improve quality. In the most recent clinical governance meeting minutes from September 2021, a clinical audit sub committee had been formed.

Managers used information from the audits to improve care and treatment. The service undertook monthly performance reviews to analysis the effectiveness of the service. This included reviews on key performance indicators including trends and analysis of performance and RAG (Red, Amber and Green) ratings as a way of indicating quality improvement areas. They utilised data from internal and external information including key performance indicators.

The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.

Daily exception reporting was in place to review any breaches and incidents. The service also fed into monthly operations and performance meetings which took place, such as the risk and continuous improvement group and clinical governance committee. They included in-depth monitoring and oversight of the governance and management of the service. The service had one key performance indicator to perform six surgical procedures per month which it has consistently met over the past 12 months. No audit of post-surgical infections had taken place as the service had no infections to report since its registration in January 2019. However, patients were being advised to contact their GPs through post-operative follow up calls. The service currently did not have a process to monitor this or confirm which patients subsequently had confirmed infections.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. The service fed into two risk registered, one corporate and once clinical. We reviewed both and saw clear actions, mitigation, ownership and review dates recorded along with impact scores.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The service had oversight of a business continuity plan provided under service level agreement from the host hospital. Staff we spoke with were aware of this and had received training in dealing with major incidents though their main employer.

As part of the business continuity plan, back up emergency generators were tested and in place in case of failure of essential services.

Requires Improvement

Surgery

Through the service level agreement (SLA) held with the host site, the service received medical device and medicine alerts through the MHRA Central Alerting System (CAS). Alerts were acted on by the host site and the service managers were kept informed of anything which might impact the delivery of surgical services.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There was a holistic understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances. 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 enough access to information.

Quality and sustainability both received enough coverage in relevant meetings at all levels. The service used performance information, which was reported and monitored, and management and staff were held to account. Meetings with commissioners took place and the service provided performance reports.

There were clear and robust service performance measures, which were reported and monitored. The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses and 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. Staff were aware of the actions to take in the event of a data security breach.

Engagement

Leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the services and culture. The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. They undertook quarterly patient surveys. Any concerns noted in the results or within a verbal or written complaint were reviewed and actions taken. There was an active log for feedback and actions which covered the whole Gloucestershire urology pathway, however, there had been no specific feedback which warranted adjustments which was specific to the service.

Staff employed by GP Care UK were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. Staff could describe the systems in place to give feedback. We saw evidence of feedback opportunities for staff such as the annual staff survey and how the findings were fed back to staff. Results from July 2021 showed more than 98% of employees believed the organisation looked after their health and wellbeing. The survey also showed 98% of staff were clear about their roles and responsibilities, compared to 88% in the previous years' survey, and 96% believed the organisation was well managed. However, 22% of staff flagged they lacked confidence to speak up and challenge if something was not being done correctly.

The service and provider took steps to improve staff wellbeing through provision of wellbeing training. The service had recently trained four mental health first aiders.

Requires Improvement

Surgery

The service and provider were transparent, collaborative and open with stakeholders about performance. They met with commissioners and provided performance reports. They also provided challenge to commissioning decisions, keeping patient access and experience at the forefront.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Leaders and staff strived for continuous learning, improvement and innovation. There was a focus on continuous learning, safety and improvement.

There were standardised improvement tools and methods, which allowed the service to make use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements across the whole urology pathway.

Staff regularly took time out to work together to resolve problems. Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not make sure there was a suitable escalation process to deal with medical emergencies in place at the host site. **Regulation 12 (2) (b)** The service had not established a way to record and report all suspected and confirmed post-surgical infections. **Regulation 12 (2) (h)** The service did not ensure medicines administered under any third-party agreements were handled, administered and recorded safely and in line with legislation. **Regulation 12 (2) (g)**

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have a formal process for managing and monitoring any service level agreements (SLA) the service has with any third parties. **Regulation 17 (2) (b)**