Health and Adult Social Care Overview and Scrutiny Committee – Supplementary agenda no. 1

A meeting of the Health and Adult Social Care Overview and Scrutiny Committee will be held on:

Date: 30 September 2014

Time: 6.30pm

Venue: Meeting Room 9 - Level 3, Gun Wharf, Dock Road, Chatham ME4 4TR

Items

5 Medway NHS Foundation Trust **(Pages 3 - 22)**

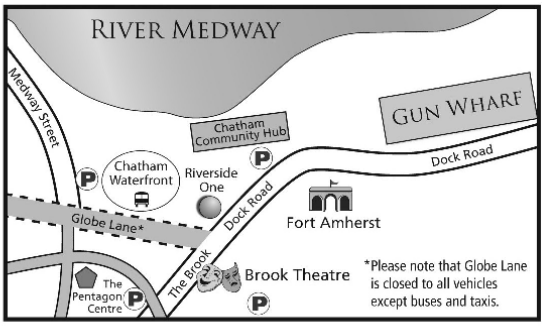
This addendum includes details of a Care Quality Commission inspection report, which was released on Wednesday 24 September 2014, and an exempt appendix relating to a confidential briefing from NHS Medway Clinical Commissioning Group (CCG)

13 Exclusion of the press and public **(Pages 23 - 28)**

This report summarises the content of the appendix to agenda item 5, which, in the opinion of the proper officer, contains exempt information within one of the categories in Schedule 12A of the Local Government Act 1972. It is a matter for the Committee to determine whether the press and public should be excluded from the meeting during consideration of this document.

For further information please contact Rosie Gunstone, Democratic Services Officer on Telephone: 01634 332715 or Email: democratic.services@medway.gov.uk

Date: 26 September 2014



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A summary of this information can be made available in other formats from **01634 333333**

If you have any questions about this meeting and you want to speak to someone in your own language please ring **01634 335577**

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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

30 SEPTEMBER 2014

MEDWAY NHS FOUNDATION TRUST – CQC INSPECTION – ADDENDUM REPORT

Report from: Barbara Peacock, Director of Children and Adults

Author: Rosie Gunstone, Democratic Services Officer

Summary

This addendum includes details of a Care Quality Commission inspection report, which was released on Wednesday 24 September 2014, and an exempt appendix relating to a confidential briefing from NHS Medway Clinical Commissioning Group (CCG).

1. Background

1.1. Since despatch of the agenda for this meeting the Care Quality Commission has released its inspection report from its unannounced inspection of the Accident and Emergency Department at Medway Maritime Hospital on 27 and 28 July 2014, attached at Appendix 1. Inspectors have since carried out a further unannounced inspection and have taken further action. The report from that further inspection – representing a more up to date view of the department – will be published in the next few weeks.

1.2. NHS Medway CCG has supplied a confidential briefing note notifying the Committee of immediate action it is proposing to take in response to the findings of the CQC Inspection. Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires a relevant NHS body to consult this Committee (or the Joint Kent and Medway Health Overview and Scrutiny Committee where a reconfiguration requires consultation with more than one local authority) where it has under consideration any proposal for a substantial development or substantial variation of the health service in Medway.

1.3. Regulation 23 (2) dispenses with the requirement for consultation in specified circumstances where a decision needs to be taken urgently and there is no time for consultation with Overview and Scrutiny. In the present case, a decision to proceed with action relating to the Accident and Emergency

Department at the hospital has been taken without allowing time for consultation with this Committee, the KCC Health Overview and Scrutiny Committee or the Joint Kent and Medway HOSC. The reasons for the decision to take the action proposed without consultation with Overview and Scrutiny are set out in full in the exempt appendix to this Addendum report.

1.3. The Committee has the power to report to the Secretary of State if it is not satisfied that the reasons given by the NHS for concluding that a decision had to be taken without allowing time for consultation with overview and scrutiny are adequate.

Background papers:

None.

Lead officer: Rosie Gunstone, Democratic Services Officer Tel: (01634) 332715
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Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Medway Maritime Hospital

Windmill Road, Gillingham, ME7 5NY

Tel: 01634833824

Date of Inspections: 28 July 2014
27 July 2014

Date of Publication:
September 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services ✖ Action needed

Details about this location

Registered Provider	Medway NHS Foundation Trust
Overview of the service	Medway Maritime Hospital is part of the Medway NHS Foundation Trust, providing care to the whole population. The site includes a range of services for people from Medway and Swale, and from other areas in Kent. It is situated in the town of Gillingham. The Trust's website gives details of the services offered, such as Maternity care, Orthopaedics, Neonatal Unit, Accident and Emergency, and Macmillan Cancer Care Unit.
Type of services	Acute services with overnight beds Acute services without overnight beds / listed acute services with or without overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 27 July 2014 and 28 July 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information sent to us by commissioners of services and were accompanied by a specialist advisor.

What people told us and what we found

On 31 December 2013 we carried out an unannounced inspection of the Emergency Department (ED) at Medway Maritime Hospital in response to information we had received from an anonymous source regarding the safety and effectiveness of the ED. We found that the service was failing to meet the national standards that people should expect to receive. As a result, we issued formal warning notices to Medway NHS Foundation Trust, telling them that they must improve in a number of areas within a specified period of time.

Medway Maritime Hospital was inspected again as part of a comprehensive inspection of Medway NHS Foundation Trust because Medway NHS Foundation Trust was rated as high risk in the CQC's intelligent monitoring system and the trust had been placed into 'special measures' in July 2013 following a Keogh review. This inspection took place between 23 and 25 April 2014 with an unannounced inspection visit on 1 May 2014.

As a result of the comprehensive inspection, overall, the hospital was rated as inadequate. We rated it good for being caring but improvement was required in providing effective care and being well-led. The safety of the hospital and being responsive to patients' needs were rated as inadequate. Whilst some core services were rated as good overall, for example critical care and services for children and young people, the emergency department and surgical services were both rated as inadequate.

We carried out a further unannounced inspection of the ED on 27 and 28 July 2014 to follow up on our findings in April and in response to us receiving information of concern from two separate sources. On 28 July 2014 we reviewed the surgery department to determine whether the trust had commenced making the necessary improvements to the service.

We were accompanied by specialist advisors in the fields of emergency medicine and surgery on 27 and 28 July respectively.

Our key findings were as follows:

The ED remained in a state of crisis with poor clinical leadership. This was despite there being an ED consultant in the department at the time of the inspection and a designated Band 7 nurse in charge. Similar to our previous inspection there was no evidence that nursing, medical and other allied health professionals were working in a joined up manner.

The ED had failed to review and optimally utilise its escalation policy within the ED to avoid the need to 'stack' patients. Whilst patients were being stacked they were not undergoing regular nursing observations, and were not being seen in a timely manner by medical staff. This was not due to the department being 'overrun' with patients (there were empty cubicles at the time of the inspection) but rather due to poor organisation of staff and lack of appropriate prioritisation of patients.

The ED continued to fail to ensure that children attending the department underwent initial assessment which was in line with national standards.

The Trust had failed to ensure that fire exits remained accessible and free from obstructions at all times. This was specifically related to the Vanguard unit in the ED whereby one exit was blocked with equipment trolleys and also on Victory ward where an exit was blocked with two hoists and an equipment trolley. In both areas these issues were brought to the attention of the nurse in charge at the time of the inspection.

Patients undergoing surgical procedures in the main theatre department continued to experience delays being transferred from the recovery area to ward beds.

Patients waiting for surgery continued to be cancelled for a range of reasons and the process of managing patients requiring non-elective surgery remained informal and un-structured although we were told that initiatives had been proposed to streamline the CEPOD service, commencing in September 2014.

As a result of this inspection, and considering the findings from our comprehensive inspection in April 2014, we have asked the trust to provide us with immediate assurances that necessary action will be taken to safeguard patients from the risk of harm. We have, and continue to liaise with external stakeholders including Monitor, NHS England and local clinical commissioning groups who have agreed a to work in partnership to support Medway Maritime Hospital. We will continue to monitor the performance of the trust and will report on any regulatory action we may take in the future.

You can see our judgements on the front page of this report.

What we have told the provider to do

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not being planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

Emergency Department (ED):

Facts and data about the ED's current performance:

Aggregated data from NHS England indicated that between 6 April 2014 and 29 June 2014 25,277 patients attended the emergency department at Medway Maritime Hospital. 86% of patients were admitted, transferred or discharged within 4 hours of arrival; this compares with the national target of 95% of patients being admitted, transferred or discharged within 4 hours of arrival. From the time that a senior clinician had made a decision to admit a patient, 515 patients experienced delays of between 4 and 12 hours before formally being admitted to the hospital.1 patient was reported as waiting for more than 12 hours from the time a decision to admit the patient had been made. It should also be noted that due to delays in the decision to admit being made, it was a regular occurrence for patients to be in the department for over 12 hours. At the time of our inspection four patients had been in the department over 12 hours, and one patient had been in the department for over 20 hours.

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The England FFT average score for emergency departments in June 2014 was reported as 53. Medway Maritime Hospital scored -5 for the same month (significantly worse than the national average) with 277 patients stating that they would be extremely likely to recommend the service to friends or family versus 146 who were extremely unlikely. The ED scored -1 for May compared with 54 nationally (response rate of 17% vs 19.1% nationally) and 10 for April compared with 55 nationally (response rate of 16.8% vs 18.6% nationally).

Service planning and delivery to meet the needs of people:

During our comprehensive inspection of the ED in April 2014 we found that staff were not routinely utilising the trust patient flow and escalation policy when the department experienced delays in patient flow. During this most recent inspection we were told by a senior member of staff that members of the ED team had not been utilising the patient flow and escalation policy for a period of two weeks prior to our inspection. When asked the reason as to why this was the case, the senior staff member was not able to give us an explanation, stating that the department was "In a state of crisis" and that there was little in the way of a relationship between the nursing and medical leads. We reviewed a selection of patient records and found that there was no evidence that where patients were experiencing delays in being seen by specialist teams, staff had not escalated those patients to the appropriate lead consultant as per the trust policy.

Initial assessment and management of patients:

We identified that not all patients were having prompt initial checks to identify their individual needs, and care pathways were not all being followed effectively.

During the comprehensive inspection of April 2014, we were told that the Vanguard Unit (a temporary structure located externally to the main ED) could accommodate four trolleys and two chairs. On 27 July 2014 there were four patients on trolleys and one patient was in a chair. Staff working within the Vanguard unit informed us that the unit had been open for approximately one hour prior to our arrival. We were previously informed that between the hours of 09:00 and 20:00 each day, patients arriving by ambulance were seen by a middle grade doctor within the Vanguard Unit. This process, referred to as STAR (Senior Treat and Review) was previously observed to be an effective process. We were told that patients were expected to spend no more than 30 minutes in the Vanguard unit before being transferred to an appropriate area within the main ED. However, on 27 July 2014, the five patients within the Vanguard Unit had been waiting for periods of up to one hour and had not been reviewed by a clinician. One patient had initially been assessed by a nurse who had carried out initial diagnostics. However, due to a deranged result with the initial diagnostic test, an order had been placed for the test to be repeated after 20 minutes; we found that after one hour and ten minutes, this test had not been repeated. We found that although nursing observations had been undertaken at some point during the patients' admission, the time was not documented and no early warning score (EWS) was calculated. This was despite one patient having a potentially dangerous heart arrhythmia and another with chest pain. There was no cardiac monitoring facilities in the Vanguard Unit.

Six children were observed to have been waiting for initial triage in the paediatric ED for periods of up to 1hour and ten minutes on 27 July 2014. The College of Emergency Medicine recommends that all patients are should undergo a face-to-face encounter with a trained health care professional within 15 minutes of arrival into the ED. The CEM further suggests that the concept of triage is a complex decision making process designed to manage clinical risk. One child, who presented with a head injury, had been waiting for one hour. We reviewed the documentation for the child; a "Paediatric Initial Assessment" form was attached to the front sheet of the child's care record. The only section of the assessment that had been carried out was the initial section entitled "Illness - Response" referring to the behavioural response of the child. "Alert" was the only section to have been circled.

We reviewed each of the six Paediatric Initial Assessment forms that were available. Three forms were empty indicating that no initial assessment had been carried out, whilst the remaining three were only partially completed. Furthermore, the delay in triage meant that the children were not being offered analgesia in a timely manner. The College of Emergency Medicine Clinical Effectiveness Committee recommends that the standard of analgesia for moderate and severe pain within 20 minutes of arrival to the ED should be applied to all children. One child had sustained an injury to their foot. The Paediatric Initial Assessment form indicated that the child was complaining of pain but there was no evidence that any analgesia had been offered and there was no recorded pain score. Another child was also reported to have complained of pain but again there was no evidence that they had been offered any analgesia and there was also no age appropriate pain assessment having been undertaken during the initial assessment.

It was therefore not possible for the Provider to be assured that initial assessments were being undertaken on all children attending the department; children were being seen in the order they arrived into the department as compared to staff utilising the trust's chosen triage assessment tool to ensure that the more acutely unwell child was assessed and prioritised for treatment.

One patient had presented with a fracture. Their care record demonstrated that the patient had waited approximately 1 hour and thirty minutes before an initial pain assessment had been carried out; from this time the patient then waited another thirty minutes before pain relief was offered. Staff carried out an additional pain assessment two hours after the first dose of medication, at which time additional analgesia was provided to the patient.

We noted that another patient had presented to the department with a potentially life threatening infection (neutropenic sepsis). The patient waited a total of four hours and forty minutes before receiving their first dose of antibiotics. The College of Emergency Medicine (CEM) suggests that it is the "Early recognition and management of sepsis that saves lives" and that the CEM recommends that at least 50% of patients receive antibiotics within one hour of arrival and that all patients receive antibiotics before leaving the ED (which should be within four hours). The UK Sepsis Trust recommends that patients are administered antibiotics within one hour of presentation to the emergency department. The patient waited for two hours before initially being seen by an ED clinician and then another one hour and thirty minutes before being seen by a medical specialist. This meant that not only did the patient experience delays in being assessed, but that when they were, the appropriate medication (antibiotic) was not given at the first opportunity, i.e. by the ED clinician.

Our specialist advisors reviewed a total of 70 patient records. Of those 70 records, 38 were found to be of inadequate quality with wide ranging omissions such as the time of assessment, records of care not being recorded, treatment plans and initial patient assessments and risk assessments being only partially completed and the designation of health care professionals providing care and treatment to children not being recorded. This was highlighted as a significant concern at the time of the comprehensive inspection in April, however no improvement has been made. There was no evidence that the department undertook any form of notes audit, either to assess the comprehensiveness of documentation or appropriateness of clinical decisions.

In conclusion, in terms of the Emergency Department at Medway Maritime hospital we found no evidence of improvement following our inspection in April. The team had significant concerns surrounding the apparent inability of the department to cope with even

a routine number of patients attending, let alone when surges of activity occur. Despite the report describing immediate areas of concern (such as poor documentation and blocked fire exits) no sustained progress in these had been made. Staff appeared resigned to the situation, and long patient waits for even urgent treatment had become normalised. The leadership of the department was found to be inadequate at the time of the comprehensive inspection. From what was witnessed during our repeat visit insufficient progress in addressing this concern had been made by the department or trust.

Surgery:

Facts and data about the surgery directorate's current performance:

Nationally agreed standards indicate that when a patient's operation is cancelled by the hospital at the last minute for non-clinical reasons, the hospital should offer another binding date within a maximum of the next 28 days, or fund the patient's treatment at the time and hospital of the patient's choice. The trust reported that between April and June 2014, 168 elective operations were cancelled at the last minute for non-clinical reasons. Zero patients were reported as not being treated within 28 days of the last minute of cancellation (zero reported breaches).

Patients undergoing surgical procedures in the main theatre department continued to experience delays being transferred from the recovery area to ward beds.

We observed the surgical department struggling to cope with the volume of patients, which was in part due to a high number of medical patients occupying surgical beds impacting on surgical pathways. During the inspection, it was apparent that the department was struggling to cope with patient flow, appropriate bed allocation and timely discharges. We found recovery struggling to care for the number of patients who did not have an allocated ward bed. This had a knock-on effect on productivity in the department.

During the comprehensive inspection in April 2014 we found that due to poor flow through the hospital, patients experienced delays being transferred from the recovery area to ward beds following surgery. At this inspection we found that patients continued to experience delays. The recovery team were routinely monitoring the delays that patients experienced. In May 2014 305 patients experienced delays of which 251 were directly attributed to there being no bed for them to be transferred to. In total, 35.5% of all patients who received post-operative care in the recovery department were delayed in being transferred to a ward or other appropriate clinical area.

A review of the data provided by the trust demonstrated that patients waiting to be transferred to the Sunderland day care unit were most likely to be delayed in being transferred back, followed by the pre-operative care unit (POCU). During our inspection, we visited the pre-operative care unit (POCU). There were 7 chair spaces allocated to patients who had been admitted pre-operatively. 13 bed spaces previously allocated to the POCU were occupied by medical outliers (the term outliers refers to patients who have been admitted to the hospital under a specialist service for which there are no beds available on that specialist ward and therefore placed on another ward). Five patients who had been listed for elective day care surgery were seen to be waiting in the POCU waiting room and had yet to be allocated a pre-operative bed space. We were told that delays in transferring patients from the recovery department back to the ward area led to delays in theatre as there was a "bottleneck" in the system. Staff reported that they were

"Frustrated" with the lack of action with regards to the hospital resolving the issue of flow hospital wide. This was because procedures were being cancelled and patients were being cared for in inappropriate areas such as the recovery area, late into the evening due to a lack of beds throughout the hospital.

Patients waiting for surgery continued to be cancelled for a range of reasons and the process of managing patients requiring non-elective surgery remained informal and un-structured although we were told that initiatives had been proposed to streamline the CEPOD service, commencing in September 2014.

In June 2014, 104 operations were cancelled (of which 8 were cancelled at the request of the patient) and in July 2014, 91 operations were cancelled (4 were patient initiated cancellations). We reviewed the CEPOD theatre booking list dating from 1 July – 27 July 2014. The reasons given as to why operations were cancelled ranged from:

- Out of time in surgery (3 cases)
- More urgent case (20 cases)
- Patient unfit or too unstable for surgery (6 cases)
- Anaesthetist busy in the resuscitation area in ED (1 case)
- Patient had eaten (3 cases)
- Patient refused or self-discharged (5 cases)
- Recovery full (1 case)

Since our April inspection the trust had appointed a consultant theatre lead to oversee the theatre department, with a specific remit of reviewing the effectiveness of the CEPOD list, recovery and the cancellation rate. We were told, but were not provided with any evidence, that the band 7 sister/charge nurse cohort within the main theatre department would, as of September 2014, commence working week long shifts so that greater oversight of the CEPOD list could be provided. This would allow the department some degree of ownership over the CEPOD list which in turn would offer consistency. The remit of the CEPOD co-ordinator was to allow one person to manage the list and to coordinate with the emergency theatre team and junior doctors who were routinely responsible for booking space on the non-elective theatre list.

During this inspection an external agency had been invited to review the effectiveness of the theatre department. It was identified as part of this review that a proportion of cases listed on the CEPOD schedule could have been placed on the elective theatre list, therefore improving the effectiveness of the CEPOD list and reducing the number of cancelled procedures that were taking place.

We have judged that since our inspection in April 2014, whilst some minor improvements have been made to in an attempt to improve the effectiveness and safety of the surgery division, these improvements had not had sufficient time to be embedded into practice.

Therefore, the trust continues to fail to ensure patients are protected from the risks of receiving care or treatment that is inappropriate or unsafe because they are failing to plan and delivery care which meets the individual needs of people whilst also ensuring their safety and welfare.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

30 SEPTEMBER 2014

EXCLUSION OF PRESS AND PUBLIC

Report from/Author: Perry Holmes, Monitoring Officer

Summary

This report summarises the content of an exempt appendix which, in the opinion of the proper officer, contains exempt information within one or more of the categories in Schedule 12A of the Local Government Act 1972. It is a matter for the Committee to determine whether the press and public should be excluded from the meeting during consideration of this document.

1. Recommendation

1.1 The Committee is required to decide whether to exclude the press and public during consideration of the following documents because consideration of this matter in public would disclose information falling within one of the descriptions of exempt information contained in Schedule 12A to the Local Government Act 1972, as specified below, and, in all the circumstances of the case, the public interest in maintaining the exemption, outweighs the public interest in disclosing the information.

1.2

Report Title	Medway NHS Foundation Trust
Agenda Item	Exempt Appendix
Summary	This exempt appendix contains key financial information.
Category of exempt information (Schedule 12A of the Local Government Act 1972)	Not for publication under paragraph 3 of Schedule 12A of the Local Government Act 1972 – information relating to financial or business affairs of any particular person (including the authority holding that information).

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Background Papers: None

Document is Restricted

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