HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

11 DECEMBER 2014

MEDWAY MARITIME HOSPITAL – CQC INSPECTION

Report from: Barbara Peacock, Director of Children and Adults

Author: Julie Keith, Head of Democratic Services

Summary

This report advises the Committee of the findings of the unannounced Care Quality Commission (CQC) Inspection of the Emergency Department at Medway Maritime Hospital on 26 August 2014. The Inspection report was published on 26 November 2014. Representatives of Medway Clinical Commissioning Group and the Medway Foundation Trust will be present to respond to Members' questions and provide an update on progress in improvements being made in response to CQC findings.

1. Budget and Policy Framework

1.1. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

2. Background

2.1 On 23-25 April and 1 May 2014, the Care Quality Commission (CQC) undertook a comprehensive inspection of Medway NHS Foundation Trust Medway Maritime Hospital. The inspection on 23-25 April was an announced inspection and was carried out because the 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. The subsequent inspection on 1 May 2014 was unannounced. The report from that inspection was released on 10 July 2014 and rated the hospital, overall, as inadequate. The CQC rated the hospital good for being caring but stated that 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. This was considered by the Committee, together with the MFT Improvement Plan at a special meeting of the Committee on 6 August 2014.

2.2 At its next meeting on 30 September 2014 the Committee considered a Care Quality Commission report from a further unannounced inspection of the Accident and Emergency Department at Medway Maritime Hospital on 27 and 28 July 2014, together with an update on the improvement plan being taken forward by Medway Foundation Trust. The Committee was advised of a proposed review of access to emergency and urgent care across North Kent. It was agreed that any proposals for changes arising from this review are subject to statutory consultation by the CCG with this Committee under regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Scrutiny) Regulations 2013. The regulations require the CCG (and other "responsible persons") to consult Overview and Scrutiny on any proposal for a substantial development or variation in the provision of the health service in Medway.

2.3 On 30 September the Committee was also notified that Inspectors had since carried out a further unannounced inspection of the emergency department (on 26 August) and had taken further action. The report from that further CQC inspection on 26 August – representing a more up to date view of the department – was published on 26 November.

2.4. Attached at appendix 1 is a copy of the full Care Quality Commission (CQC)'s report of the unannounced inspection of the Emergency Department at Medway Hospital on 26 August 2014. Appendix 2 to this report is the letter from Medway Foundation Trust to the Chairman of the Health and Adult Social Care Overview and Scrutiny Committee, together with the press release written by MFT to coincide with the release of the inspection report.

2.5 Representatives from the Medway Clinical Commissioning Group and the Medway Foundation Trust will be present to respond to Members' questions and provide an update on the improvement journey.

3. Risk Management

3.1. There are no specific risk implications for Medway Council arising directly from this report.

3.2. The Council is responsible for improving health outcomes as measured by the Public Health Outcomes Framework and does this in partnership with the NHS. Failure to address the findings of the CQC report could impact adversely on improving local health outcomes.

4. Legal and Financial Implications

4.1. It is anticipated that a small part of the performance element of the 'Better Care Fund' will be dependent upon meeting targets around emergency admissions to the hospital. Failure to meet the target would not mean that this funding was lost to Medway, but it would be diverted from the 'pooled budget' and passed to the CCG to meet the unbudgeted activity within the acute

sector. The specific details around this have yet to be agreed at a national level.

4.2. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and in particular, relevant information provided to it by a local Healthwatch organisation. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution. The Committee may make reports and recommendations to relevant NHS bodies and health service providers who can be required to respond formally within 28 days of a request for a response.

4.3. Recently published Department of Health guidance to support Local Authorities and their partners to deliver effective health scrutiny (published June 2014) emphasises the primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe.

4.4. The guidance states that local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. In the light of the Francis report local authorities are advised in the guidance to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

5. Recommendations

5.1. The Committee is asked to consider the findings of the latest unannounced CQC Inspection of the Emergency Department at Medway Maritime Hospital and to seek assurances from the Medway Clinical Commissioning Group and MFT about the direction of travel in achieving the improvements required.

Background papers:

None.

Lead officer:

Julie Keith, Head of Democratic Services
Tel: (01634) 332760 Email: julie.keith@medway.gov.uk

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 Inspection: 26 August 2014

Date of Publication: November 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	✖ Enforcement action taken

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 26 August 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 given to us by the provider and reviewed information sent to us by other regulators or the Department of Health. We talked with other regulators or the Department of Health 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.

Our key findings from our inspection on 27 and 28 July were as follows:

The ED was 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.

As a result of the inspection on 27 and 28 July and considering the findings from our comprehensive inspection in April 2014, we asked the trust to provide us with immediate assurances that necessary action would be taken to safeguard patients from the risk of harm.

On 30 July 2014 we formally wrote to the Chief Executive of Medway NHS Foundation Trust setting out our concerns and to request the necessary assurances that appropriate action would be taken to ensure the safety and welfare of patients who used the service. The trust responded, in a timely fashion, to our request for a robust action plan.

We carried out a further inspection of the ED on 26 August 2014; we were accompanied by specialists in the field of emergency and general medicine.

Our findings from our inspection on 26 August were:

The ED continued to lack any form of effective clinical leadership and there remained a lack of cohesive working amongst nursing, medical and allied healthcare professionals.

The process of initially assessing patients in a timely manner remained flawed; in some instances we found that patients were experiencing delays of more than two hours before any effective clinical intervention or treatment was commenced.

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

We have taken enforcement action against Medway Maritime Hospital to protect the health, safety and welfare of people using this service.

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 ✖ Enforcement action taken

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 neither planned nor 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 and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Emergency Department (ED):

Facts and data about the ED's current performance:

The performance of the emergency department during quarter 2 (06 July – 29 September 2014) was markedly worse than that of quarter 1 (06 April 2014 to 05 July 2014); this was despite there being fewer attendances during quarter 2. Data from NHS England indicated that between 6 April 2014 and 05 July 2014, 25,277 patients attended the emergency department at Medway Maritime Hospital. This was compared with 24,344 patients attending the ED between 06 July and 29 September 2014.

During quarter 1, 86% of patients were admitted, transferred or discharged within 4 hours of arrival; the national target of patients being admitted, transferred or discharged within 4 hours of arrival is 95%. During quarter 2, 83.7% of patients were admitted, transferred or discharged within 4 hours.

In quarter 1, 515 patients experienced delays of between 4 and 12 hours before formally being admitted to hospital. This compared with 724 patients during quarter 2. Furthermore, during quarter 2, 6 patients were reported as waiting for more than 12 hours from the time a decision to admit was made; this compared with 1 patient experiencing a delay during quarter 1.

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 August 2014 was reported as 57. Medway Maritime Hospital scored 8 for the same month (significantly worse than the national average) with 212 patients stating that they would be extremely likely to recommend the service to friends or family versus 65 who were extremely unlikely. The ED scored 4 for July compared with 53 nationally (response rate of 16.6% vs 20.2% nationally).

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.

In response to our findings from our inspections of April and July 2014, the trust closed the Vanguard Unit shortly following our inspection of 27 July 2014. The process of STAR (Senior Treat and Refer) was moved to an area within the main ED. We had received information from external sources prior to our visit on 26 August 2014 that some patients were still experiencing delays in having an initial assessment and clinical review upon their arrival to the ED.

Information provided by the trust reported that between 03 September and 24 September 2014, of the 6,525 patients who attended the ED, 300 patients (5.06%) experienced delays of more than 15 minutes from the time they arrived to undergoing an initial assessment. The College of Emergency Medicine (CEM) recommends that all patients should undergo a face-to-face encounter with a trained health care professional within 15 minutes of registration into the emergency department.

Senior staff within the ED raised concerns that the closure of the Vanguard unit had generated additional pressures within the main ED. The STAR process had been relocated to the departments' observation area and so there was an overall reduction in bed capacity within the department. We found that the concept of STAR, whilst consistent with the recommendations of the College of Emergency Medicine, was ultimately flawed. We found that once patients had undergone an initial assessment by a senior clinician, they remained within one of the four dedicated STAR bays until an appropriate space was made available within the majors department. Due to on-going capacity issues across the hospital, availability of bed spaces within the majors department was observed to be limited. We noted that the majors department was, on the day of the inspection, calm, whereas the STAR area was chaotic and unorganised.

Due to the poor management of patients through STAR, new patients presenting to the ED were experiencing long delays in being assessed. We found that the poor management of patients within both STAR and the majors department was associated with a lack of any formal pathway for the movement of stable patients.

Furthermore, we noted that there was often confusion with the movement of patients from the ED to a ward bed. In one instance, we found that an elderly patient who had been in the department for over twelve hours had been assigned a ward bed, only for the senior nurse in charge of ED to contact the ward to be told that the bed was no longer available. It is also important to note that whilst nursing staff had carried out a skin integrity assessment for this patient which resulted in the patient being identified as being at high risk of pressure damage, the patient remained on a trolley for a period of nine hours. The local policy was that all patients were to be transferred from a trolley to a bed within 6 hours of arrival.

Upon arrival to the ED, we reviewed the departments' computer system, symphony, and

found that 13 patients were awaiting an initial medical assessment. Five patients had been waiting for periods of between 74 and 116 minutes from first registration and had yet to undergo an initial assessment by a trained health care professional.

During the inspection on 26 August we found that one elderly patient was noted to have presented with a potentially life threatening gastrointestinal disorder and had been waiting two hours in the holding bay without intravenous fluids or an initial clinical assessment being carried out. We asked nursing staff about the most appropriate course of treatment for the patient; they responded by suggesting that the patient should, at the very least, be receiving intravenous fluid until such time that they had been appropriately examined and assessed by a clinician.

We were told by a senior member of the ambulance trust that the previous day a patient with known arrhythmia had a cardiac arrest in a corridor while awaiting their first clinical assessment.

One patient had been transported to the department by ambulance having suffered from a fractured neck of femur. The patient did not undergo an initial Senior Treat and Refer assessment for a period of two hours and 22 minutes. A review of the patients' record indicated that staff had not undertaken any form of physical observation for a period of three hours.

Our specialist advisors reviewed a total of 50 patient records. We found that whilst some improvement had been made in the completion of local forms such as the Paediatric Initial Assessment form, there remained wide ranging omissions such as the time of assessment, records of care not being recorded and initial patient assessments being only partially recorded. In almost all of the records that we reviewed, a written summary of any discussion that had taken place or advice given upon discharge had not been recorded. We were told that medical staff issued a discharge summary which was forwarded to patients' General Practitioners which detailed any treatment and advice they received. This was highlighted as a significant concern at the time of the comprehensive inspection in April and again in July, however it is disappointing that only little improvement had been made.

There still remained 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 little evidence of improvement following our inspections in April and July. Whilst the trust had provided us with an action plan to address the plethora of issues we had identified, the pace of change remained slow; the ability to introduce change was hindered by the continued lack of leadership within the department however we were reassured that the trust was in the process of appointing experienced nurses to lead the workforce as well as commissioning external specialists in emergency medicine to help improve the safety of the department.

We have judged that the trust continues to fail to ensure that 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. We have taken the necessary action to impose urgent conditions on the trust's registration. Namely those conditions are that:

1. The Registered Provider must operate an effective system which will ensure that patients attending Accident and Emergency at Medway Maritime Hospital have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011, a copy of which is attached to this condition ("the CEM standard") or such other recognised professional processes or mechanisms as the Registered Provider commits itself to.

2. The Registered Provider shall ensure that sufficient numbers of appropriately qualified clinical staff are employed by the Registered Provider so as to enable the Registered Provider to operate the system required by condition 1.

3. The Registered Provider shall, as soon as is reasonably possible and in any event by 4pm on 5 September 2014, describe the system operated by the Registered Provider is operating its Accident and Emergency Department at Medway Maritime Hospital so as to comply with the standards set out in condition 1 and shall:

a. Publicise the content of the said system for the staff of the Accident and Emergency Department; and

b. Provide a copy of the document describing the said system to the Care Quality Commission.

4. As part of the description of the system as required by condition 3, the Registered Provider shall explain how the Registered Provider:

a. Records the arrival time of each patient at the Accident and Emergency Department;
b. Records the time at which each patient is registered as having arrived at the Accident and Emergency Department; and
c. Records the time at which an initial clinical assessment is commenced for each patient and by whom the assessment is being undertaken.

5. From 5 September 2014, on the Friday of each week thereafter, the Registered Provider shall report to the Care Quality Commission on how many occasions the Registered Provider has failed to provide a service to a patient which fails to meet the standards set in condition 1 and, in respect of each such occasion:

a. A unique identifier for the patient;
b. The time taken between arrival and the commencement of an initial clinical assessment; and
c. The reason that the standard was not met for this patient;
d. The consequences (if any) for the individual patient of the delay in initial clinical assessment.

6. On the twenty-eighth day of each month from 28 September 2014, the Registered Provider shall submit a report to the Care Quality Commission which identifies the root causes for failure to meet the CEM standard and explains how the Registered Provider will address these causes in the form of an action plan. The subsequent month's report must:

a. Repeat this root cause analysis for any new failures to meet the CEM standard,
b. Re-evaluate the action plan considering these new failures,

c. Indicate progress made against the action plan.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

Urgent procedure to impose a condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: We consider that the Provider is not operating an effective system so as to ensure appropriate initial assessment of patients is undertaken when patients attend the Accident and Emergency Department of Medway Maritime Hospital. The Care Quality Commission considers that the failure to operate an effective system to undertake appropriate initial assessment of patients who attend the Accident and Emergency Department of Medway Maritime Hospital means that such patients will or may be exposed to the risk of harm. Regulation 9(a)(b)(i)(ii)(iii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

Appendix 2

Medway NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S OFFICE

Direct Line **01634 833944**
Fax No: **01634 825290**
Email: **Chief.executive@medway.nhs.uk**

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

Our ref: PB/MJ

25 November 2014

Councillor David Wildey
Chair
Health & Adult Social Care O&S Committee

Sent via email

Dear Councillor Wildey

Re: **Publication of Care Quality Commission report following an inspection on 26 August 2014**

I would like to make you aware of an inspection report the Care Quality Commission plan to publish this week. The report comes following an unannounced inspection of the emergency department at Medway Maritime Hospital on 26 August.

The Trust takes patient safety and patient experience very seriously and has made a number of organisational changes and put in place a number of actions since this visit to begin to address the issues raised in the report.

We realise the challenges before us and remain fully committed to providing the high quality of care our patients deserve. With the direction now being provided by the new Board of Directors, work is taking place across the organisation in a number of areas; to ensure we can provide high quality and efficient healthcare in a sustainable way.

Some longer-term projects are also nearing completion. In February next year a brand new IT system will go live that will revolutionise the way we manage patient records, and developments in our emergency care environments are taking shape, with the new children's department opening next month and specialised short stay medical wards opening at the same time.

We appreciate the cooperation and support from our local healthcare partners, who recognise that we must all work together to improve the way in which we provide care and treatment for our patients. We will continue to build on these important partnerships for an effective healthcare system.

Continued……

The full report will be available to view on the Care Quality Commission's website at www.cqc.org.uk

Please do not hesitate to get in touch if you wish to discuss the matter further.

Yours sincerely

Dr Phillip Barnes
Acting Chief Executive

Encl…… Press release strictly embargoed until Wednesday 26 November 00:01 hours

Medway NHS
NHS Foundation Trust

Strictly embargoed until 26 November 2014, 00:01 hours
Care Quality Commission's August inspection report publication

The Care Quality Commission has today published the report of their unannounced inspection of the emergency department, at Medway NHS Foundation Trust, carried out on 26 August 2014.

The Trust takes patient safety and patient experience very seriously. It has made a number of organisational changes and put in place a number of actions since this visit to begin to address the issues raised in the report.

Leadership and staffing
One of the major first steps the Trust has taken is to stabilise the Board of Directors. A number of experienced executives have been appointed and the new chair of the board commenced on 8 September 2014. The focus of the board is on improving standards of care across the hospital, improving operational efficiency and to work with our staff to provide the high quality of care our patients deserve. The Trust appointed Morag Jackson as the new chief operating officer and in her role she will focus on improving operational processes to improve patient flow and experience through the hospital – ensuring our patients receive the treatment and care they need whilst maintaining operational efficiency. Steve Beaumont has been appointed as new chief nurse at Medway to lead improvements in standards and to embed the best patient care practices.

Changes within the emergency department
The managerial structure within the emergency department has been reviewed to ensure there is experienced and visible management in place.

Two new emergency care consultants took post in September and October, there is now a dedicated head of nursing in the department and three new emergency care matrons will all be in post by 2 December. An emergency consultant lead, Dr Laurence Gant, and an experienced matron from Homerton University Hospital have worked in a support and advisory capacity over the last two months. The Trust has appointed Dr Laurence Gant for a year to manage improvements to the way in which emergency patients are cared for.

Initial patient assessment within 15 minutes
The Trust has reviewed its initial assessment process against standards set by the College of Emergency Medicine, and fully replaced the previous STAR (Senior Treat and Refer) system. Over 95 percent of patients who arrive at the department by ambulance now have an initial assessment completed within 15 minutes of arrival, and this is being sustained week on week.

Patient flow through the hospital
Work is taking place to improve patient flow throughout the hospital and to alleviate congestion in the emergency department. This includes increasing consultant presence during weekends so patients who are fit and ready to go home, can be safely discharged on Saturdays and Sundays. Operational plans are being developed to assist effective patient flow, from arrival to discharge.

Additional winter funding has been received by the Trust and this is being invested to accelerate these changes.

New emergency department for children
The new children's emergency department is due to open next month. This new department will have a dedicated entrance, three additional treatment bays – increasing the number to six – and new examination rooms to allow faster and better initial assessment and treatment.

The new layout will provide complete segregation from adults and will an enhanced environment for children, their parents, relatives and carers.

Dr Phillip Barnes, Acting Chief Executive said: "We realise the challenges before us and are fully committed to providing the high quality of care our patients deserve. With the direction now being provided by the new Board of Directors, work is taking place across the organisation in a number of areas to ensure we can provide high quality and efficient healthcare in a sustainable way.

"Some longer-term projects are also nearing completion. In February next year a brand new IT system will go live which will revolutionise the way we manage patient records, and developments in our emergency care environments are taking shape, with the new children's department opening next month.

"We appreciate the cooperation and support from our local healthcare partners, who recognise that we must all work together to improve the way in which we provide care and treatment for our patients. We will continue to build on these important partnerships for an effective local healthcare system."

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