Care Quality Commission

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Dr. Lucy Moore
Chief Executive
Colchester Hospital University NHS Foundation
Trust
Turner Road
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URGENT

20 November 2014

Dear Lucy,

Re: CQC Inspection of Colchester Hospital University NHS Foundation Trust

Following your feedback meeting with the Head of Inspection Fiona Allinson and Leanne Wilson, Inspection Manager on 12 November 2014, I thought it would be helpful and indeed important to give you early feedback from the inspection which was undertaken on 12 November 2014.

Some of the findings from the inspection are concerning, and action on them should not wait until receipt of our report. I know that you have already started to take action, but I would like to ask for your assurance of what action will be taken on each of the issues that I set out below in this letter.

A full report will be sent to you once it has completed our due processes. This letter does not replace the report but gives you an early sight of our concerns highlighted at the inspection.

Our approach
At our inspection in June 2014 we rated the trust as requiring improvement. We returned to the trust in this unannounced inspection as we had received information of concern in respect of A&E and the Emergency Admissions Unit (EAU). Our inspection considered whether those two units are currently providing safe, effective, caring, responsive and well-led services.

Before visiting, we reviewed a range of information we held and met with you on 20 October 2014. We assembled a team of eight CQC inspectors to undertake the

inspection under the lead of Ms Fiona Allinson, Head of Hospital Inspections at CQC.

As part of the inspection we:

- Spoke with senior representatives of stakeholder organisations including Monitor and NHS England and attended the Quality Surveillance Group meeting on 23 October 2014.

- Visited the following clinical areas:

    - A&E
    - EAU

- We also reviewed the serious untoward incident process at the hospital.

- Interviewed the Director of Nursing Ms Barbara Stuttle and Ms Selina Sibanda, Associate Director of Governance.

- Provided initial feedback to the Monitor and trust executives.

An overview of our findings

This inspection revealed some concerning findings and we provided feedback at the end of our visit to the senior team on site. I am setting out the key findings below and ask for your assurance of what actions are being taken on them.

We witnessed times when patients were not treated with dignity and respect. These included insufficient use of curtains and covers in A&E, and negative or abrupt manners in both units.

When we reviewed records, we found cases where there was no record that all appropriate assessments had been carried out, including assessments required under the Deprivation of Liberty Safeguards. In some cases treatment had been provided, or individuals' liberty had been restricted, without any record to show that appropriate consent or assessments had taken place.

We found that collaboration between A&E and EAU needed to improve, with EAU closing at regular intervals to admissions and A&E having to absorb extra patients awaiting a bed on a ward area. We also found that the level of dependency of patients sent to EAU from A&E was unusually high and use of the National Early Warning Scores (NEWS) was not consistently determining appropriate escalation of patients whose condition may require further intervention.

Also on the EAU we had significant concerns about how decisions on attempting resuscitation of a patient on the unit were managed.

In both A&E and EAU we found that the leadership of these areas was below an acceptable standard. In both areas we found a lack of coordination of working arrangements that met the needs of patients, and in EAU we had concerns about

the effectiveness of governance arrangements. Morale amongst staff was generally low.

We noted that staffing arrangements were not always sufficient to meet the needs of patients in both departments. We observed that staff were not adhering consistently to infection control requirements.

Next steps

Please could you write to me to set out what action is being taken on these issues, by Friday 28 November 2014 This should set out the steps that will be taken to ensure that services remain safe, effective, caring and responsive to patients' needs, and that appropriate leadership and governance are in place.

I will then consider whether any further regulatory steps are needed. I hope that your initial description of actions, and the full action plan following our full inspection report, can be both monitored and supported through the special measures arrangements that are already in place with Monitor, but I will continue to consider whether further use of CQC's enforcement powers is needed. As part of my consideration, I will consult Monitor and ensure close coordination with them of our regulatory oversight.

A full report of the inspection will be published in due course and you will have the usual opportunity to check it for accuracy.

I am copying this letter to David Bennett at Monitor.

We do not normally publish correspondence that we have with registered providers. However in this specific case, in the interests of transparency, we have decided that this letter will be placed on CQC's web site next week.

Yours sincerely

Professor Sir Mike Richards
Chief Inspector of Hospitals