Care Quality Commission
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This letter has been sent by email.

Mr. Nick Hulme
Chief Executive
East Suffolk and North Essex NHS Foundation Trust
Trust Offices, Colchester District General Hospital
CO4 5JL

Date: 8 November 2022

CQC (Care Quality Commission) Reference Number: INS2-14021943111

Dear Mr. Hulme

Re: CQC inspection of Colchester Hospital – Medical Care (Older People's Services)

Following the feedback meeting with Beth Houston, Inspector, Lesley Richardson, Inspector, Chrissie Tyrrell, Inspector, Mumtaz Goolam, Specialist Advisor on 3 November 2022, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to Giles Thorpe and your colleagues Anne Rutland, Sarah Jenkins and Emma Sweeney at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 3 November 2022 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback was:

- We asked that staff were thanked for welcoming us and taking the time to speak with us on what was a very busy day.

- We relayed positives observed and that we found staff to be welcoming, hardworking and supportive of each other.
- We found staff at all levels working together with the aim of putting the patients first and providing a safe and effective service.
- Patient records included all appropriate information, were easy to navigate and risks were clearly identified with mitigations in place.
- Staff proudly shared a range of local initiatives to support some of the wards to help with flow, discharge, and mobilisation in preparation for discharge.

However, there were some concerns found that have the potential to impact on the safety of patients, morale and wellbeing of staff. For example;

- All wards' actual staffing levels and skill mix meant staff were often overstretched. All staff we spoke with expressed concern about the impact on patient care and personal wellbeing. Some staff we spoke with were tearful, reported feeling exhausted and concerned that they were unable to care for patients well enough to keep them safe.
- We saw two patients did not have support to eat their breakfast, and one family told us that they observed other patients' food being taken away without them eating it. These vulnerable patients may have been unable to feed themselves. Staff told us that low nurse to patient ratios mean they were unable to always prioritise feeding support.
- We saw nursing staff on Peldon ward, a ward with high acuity, were overstretched and lacked leadership. The busy ward was not fully staffed, appeared messy with dirty dressings left on and around bedsides and staff unable to answer calls bells in a timely way.
- One doctor was seen with a watch and not bare below the elbows, when asked the doctor told us he was not prepared to adhere to the infection prevention control guidance.
- We saw that electronic screens in each of the nurses' stations displayed confidential patient information. This meant that staff were not complying with legislation to protect patient privacy.
- Patient files were kept in unlocked trollies, this meant patient records could be accessed by individuals without permission.
- We saw that the COSHH (Control of Substances Hazardous to Health) cupboard door was left open and unattended. This meant that vulnerable patients on the ward could access dangerous products.
- One nurse in charge told us that a vulnerable, wandering patient had a Deprivation of Liberty Safeguards (DoLS) in place, however upon checking with the nurse in charge the next day it was clear the patient did not have a DoLs. The nurse in charge assured us the patient was not being detained and that a DoLs was in process.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Catherine Morgan at NHS England and NHS Improvement.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
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If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause a delay if you are not able to give it to us.

Yours sincerely

Zoe Robinson

Head of Hospitals Inspection

c.c. Helen Taylor, Chair of Trust
Catherine Morgan, NHSEI