Embargoed: CQC rates services at Colchester Hospital requires improvement

Press release embargoed until 00.01hrs on Wednesday 8 October

Link to the embargoed inspection report is at the very end of this email
The Care Quality Commission (CQC) has again rated medical care (including older people's care) and urgent and emergency services at Colchester General Hospital, as requires improvement and taken action to protect people, following inspections that finished in May. CQC carried out these inspections in part due to safeguarding concerns and emerging safety risk for people receiving care at the hospital, run by East Suffolk and North Essex NHS Foundation Trust, and as part of CQC's ongoing monitoring of the services provided. CQC served two warning notices on East Suffolk and North Essex NHS Foundation Trust in April and May. These related to concerns about consent, safeguarding, safe care and treatment, management of services, staffing, and the safety of the premises at Colchester Hospital.
CQC has told the trust to submit a plan showing what action it is taking in response to these concerns.

Following these inspections:
Medical care (including older people's care) services have been re-rated as requires improvement overall.
Safe has declined from requires improvement to inadequate. Responsive and well-led remain requires improvement.
Effective and caring were not looked at during this inspection and remain rated as requires improvement and good respectively.
Urgent and emergency care services have been re-rated as requires improvement overall.
Safe has declined from requires improvement to inadequate.
Responsive and well-led remain requires improvement.
Effective and caring were not looked at during this inspection and remain rated as good.
The overall rating of Colchester Hospital remains requires improvement.

Hazel Roberts, CQC deputy director of operations in the East of England, said:

“When we inspected Colchester Hospital, we continued to find concerns about how people were cared for. Some of these are the same concerns we’ve already highlighted at previous inspections.
We’ve also found new concerns about the deterioration in the safety of these two services in particular. In urgent and emergency services, the department was very crowded, with people regularly treated in corridors. People said staff were kind and we saw they worked hard to meet people’s needs, but these spaces gave people little privacy or dignity. We saw people experiencing long waits.
One person in mental health crisis waited more than 100 hours for a mental health bed and staff told us another person stayed nine days in the emergency department.
People cared for in corridors weren't always checked on regularly and some people said they weren’t offered food. This created clear risks to people’s safety and wellbeing.
In medical care services, people told us they felt staff did their best in a busy service to provide care and treated them with respect. They felt confident to raise concerns.
However, there weren't enough staff to consistently meet their care needs. We saw people who missed help with eating and personal care, and staff weren't always available to provide the support people needed.
While most people said they felt safe and understood their treatment, others, particularly older people and their families, said they weren't given clear discharge plans.
Healthwatch and local health and social care providers raised similar concerns about communication when people left hospital.
Leaders at Colchester must ensure they are using the findings from CQC’s reports and putting in place effective systems enabling them to fully understand the issues and work together to drive and sustain improvements.
We’ve shared our findings with the trust so they know where improvements must be made. We’ll continue to monitor both of these services closely to ensure people receive safe care while these improvements are being made.”

Inspectors also found:
Leaders didn’t always investigate incidents in a timely way, CQC saw 40 overdue reviews at this inspection. This meant that there could be a delay in identifying learning and implementing changes in practice.

Staff didn’t always follow infection prevention and control procedures and didn't always detect and control the risk of it spreading.
Leaders didn’t always support staff, who didn’t always follow national guidance when using restraint, and de-escalation planning was poor.
Medical staff missed training targets for basic life support, safeguarding and other key areas.
Staff left hazardous substances in unlocked rooms and couldn’t always secure ward areas at night.
The hospital wasn’t always managing medicines well, which meant people weren’t consistently receiving them safely and medicines were not always kept secure.

The report will be published on CQC’s website in the coming days.