LAP assessment report

Essex Partnership University NHS Foundation Trust

LAP Assessment Report ID : LAP-1

Inspection visit date(s): 21st January 2026

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Mental health services

Acute wards for adults of working age and psychiatric intensive care units

Acute wards for adults of working age and psychiatric intensive care units

Overall	Requires improvement
Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Our view of the service

Ardleigh Ward, located at The Lakes, Colchester Hospital, is provided by Essex Partnership University NHS Foundation Trust. The ward is an 18-bed acute inpatient service for female patients.

The hospital is registered with the Care Quality Commission to carry out the following regulated activities:

• Treatment of disease, disorder or injury

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

The Care Quality Commission last inspected this location in July 2025 where the service was rated as Requires Improvement. We found 1 breach of the legal regulation 12, safe care and treatment, Health and Social Care Act regulations (2008).

We inspected the service in January 2026, the report for this inspection will be unrated and the ratings reflect the previous inspection only.

Our View of the Service

We carried out an inspection on the 21st of January 2026 due to receiving information of concern about safe staffing and high levels of self-harm on the ward. At this time there were 18 patients admitted to the ward.

At this inspection we found 3 breaches in relation to Regulation 12: safe care and treatment, Regulation 18: staffing and Regulation 20: good governance. Due to the serious concerns we found, we wrote to the trust and requested immediate actions. The trust were able to show how they had mitigated immediate risk to patients.

Staff did not respond appropriately to ligature alarms, and staff raised concerns at lack of support due to low staffing numbers.

One patient did not have a comprehensive risk assessment or appropriate planning for physical health care recorded.

Staff observed patients for more than the recommended time of 2 hours. This does not comply with best practice guidance.

Staff did not ensure the environment on the ward was safe for patients. High risk items that patients could harm themselves with, for example a bottle lid and a towel were discarded in a communal area. One patient's bedroom was extremely unkempt and included high risk items such as plastic bags and empty bottles.

Staff raised concerns at the lack of time allocated to them to complete administrative tasks, this included the recording of incidents and performing comprehensive handovers.

Staffing met establishment numbers; however, this was not meeting the needs of the ward. Staff told us staffing numbers did not always make them feel assured they could provide safe care to patients with the current establishment. Patients told us that they felt they did not get the care they needed unless they were on enhanced observations.

Bank staff were not always willing to work on the ward due to the high acuity and complex needs of the

patients, and the perceived risks should something go wrong. This led to further staff shortages.

Staff told us they felt burnt out and the ward felt unsafe.

Mental Health Act and Mental Capacity Act Compliance

Mental Health Act

The service admitted patients under the Mental Health Act 1983.

Staff received and kept up to date with training on the Mental Health Act. Training was mandatory for staff, and the compliance rate for registered staff was 86% and 92% for unregistered staff.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff could receive assistance from the Mental Health Act team at the trust, and the mental health act office provided training for all staff.

The service had clear, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff did not always record regular explanations of patients' rights, under the Mental Health Act. We looked at 6 care records and in 1 there was no record of the patient having their rights explained. In another there was 1 recent record, but nothing in the previous 6 months. Two care records showed patients' rights being regularly explained and 2 informal patients were having their rights explained to them regularly.

We were not provided with requested data regarding Section 17 (S17) leave and any occasions when the prescribed leave had not taken place. S17 leave (Mental Health Act 1983) allows patients detained in a hospital for mental health treatment to take authorised temporary leave from the ward.

Mental Capacity Act

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of the 5 principles. Training on the Mental Capacity Act was incorporated into the safeguarding adults and children training and was mandatory for staff. At the time of inspection, the compliance rate was 92% for level 2 and 93% for level 3.

Staff did not complete an assessment of each patients' capacity to consent to admission and

treatment on admission. We looked at 7 care plans and 1 showed a record of an assessment taking place. There was no record of capacity assessments in the other 6 care plans we looked at.

People's experience of the service

We spoke with 8 patients during the inspection. Some patients did not feel safe on the ward. Patient concerns included low staffing, observations not being completed properly and staff not engaging with patients. They also raised slow responsiveness to incidents, including self-harm, and fear of violence and aggression from other patients. We spent time observing daily life and routines to help us to understand their experiences. Staff did not always interact with patients whilst on 1:1 observations, however we did see some patients engaging in art therapy throughout the day.

A patient told us they had been repeatedly assaulted by another patient. They told us that staff do not address physical violence. Another patient told us that staff laughed at them during a restraint in which the patient had been injured.

A family member told us they did not feel their loved one was receiving good care and described staff as 'unprofessional'. They were concerned the ward was always short staffed and raised concerns at a lack of appropriate visiting areas on the ward. However, they had received a response from the service when raising concerns and told us they attended ward rounds and the doctor was good, positive and explained things to them and the patient.

Safe

Rating Requires improvement

This means we looked for evidence that people were protected from abuse and avoidable harm.

The trust were in breach of regulation 12 (safe care and treatment), regulation 18 (staffing) and Regulation 17 (Good governance).

Managers did not ensure the ward was safe. We observed staff failing to respond to incidents appropriately, including a failure to respond to ligature alarms. Staff reported a lack of support available to them on the ward when incidents occurred. They were not always allocated time to complete administrative tasks such as comprehensive handovers and the recording of incidents. This increased the risk of avoidable harm and prevented thorough risk assessments and learning from

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incidents.

Managers did not ensure that care records and risk assessments were updated after serious incidents, compromising the physical health of patients. Failure to risk assess, safeguard and learn from incidents puts patients at risk of ongoing and avoidable harm.

Managers allocated staff to complete enhanced observations for more than 2 hours consecutively, failing to comply with best practice guidance and exposing staff to tiredness and a lack of vigilance.

Leaders did not ensure that the environment of the ward was safe. Items that could be used by patients to cause harm to themselves or others were identified in communal areas, increasing risk of harm to patients. This included a discarded dirty towel on the floor in a communal area and access to bottle lids on the ward. One patient's room was extremely unkempt and messy and contained high-risk items such as plastic bags and empty bottles, posing a risk of avoidable harm.

Learning culture

Score

3. Evidence shows a good standard of care

There were 5 serious incidents recorded on the ward in the last 12 months, these included 2 incidents of self-harm including 1 of serious self-harm and 3 episodes of a patient going absent without leave (AWOL). Staff had not recorded a serious incident in the serious incident log that we saw whilst reviewing care records. Staff had not recorded a risk assessment, learning or actions recorded in relation to this.
We spoke with 11 members of staff; all knew what incidents to report and how to report them. However, we were told that due to low staffing numbers on the ward and lack of time provided by leaders to complete administrative tasks, incidents were not always recorded.
Staff completed a SWARM huddle where insights, reflections and learning took place after a serious incident of self-harm. Staff understood the duty of candour.

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Safe systems, pathways and transitions

Score

3. Evidence shows a good standard of care

The service had a clear admission policy that provided clear responsibilities to staff that would assess the placement, including the Home Treatment Team and Approved Mental Health Act Practitioners. The policy stated that a trauma informed approach was taken and the views of the person and family members were considered before deciding on admission. It included a clear pathway for people that were to be admitted to inpatient mental health wards.

We sought feedback from commissioners and external partners, however, none of them responded to our request.
Staff planned patients discharge planning from admission which was reviewed regularly.
Staff made appropriate referrals, including working with the acute hospital when a patient was transferred there. We also saw partnership working with discharge coordinators, community mental health teams and crisis teams.

Safeguarding

Score

3. Evidence shows a good standard of care

The service had a safeguarding policy and clear processes in place for staff to follow. Staff received training on how to recognise and report abuse, appropriate for their role. All staff completed mandatory safeguarding training modules and compliance was between 92% and 100%.

The trust had a safeguarding lead, and other staff undertaking safeguarding roles. Ward staff knew how to raise safeguarding concerns. In the previous 3 months staff had made 14 safeguarding referrals. Safeguarding concerns related to a variety of incidents including sexual safety and neglect. One safeguarding incident was observed by an external visitor whilst a

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patient was on 1:1 observations and not seen by observing staff whose attention was elsewhere. The patient was able to self-harm requiring urgent physical health care.

The safeguarding team tracked the recording of safeguarding referrals, including actions taken.

Staff followed safe procedures for children visiting the service. Children were not allowed on the ward. At the time of inspection, the family room was unavailable due to refurbishment so children could only visit off the ward.

Staff provided a patient with a prohibited item leading to an incident that subsequently required surgery.

A safeguarding had been raised due to staff arguing in front of patients who tried to intervene. These matters exposed patients to an increased risk of serious harm and did not provide a safe or therapeutic environment for patients.

Involving people to manage risks

Score

3. Evidence shows a good standard of care

We looked at 7 care plans and risk assessments. All patients had a risk assessment completed at admission. There were gaps in patient assessments including physical health assessments and management plans.
Incidents and risk were not always integrated into care plans, and incident numbers were not always present preventing cross referencing to enable ongoing risk assessment. Risk assessments did not show family involvement and patient input was not consistent throughout the records.
Care plans were not all up to date and were not reviewed on a regular basis and not all patients had a current care plan. One did not reference psychology or occupational therapy involvement and had no medication care plan.
There had been 21 incidents of restraint between 1st November 2025 and 31st January 2026. No incidents involved prone, face down restraints. There were 2 incidents of long-term segregation, and Rapid Tranquilisation was used 11 times during the same period. There was a

restrictive practice policy in place noting individual, ward/unit and trust wide responsibilities. All patients had access to an Independent Mental Health Advocate (IMHA) during their stay at the hospital. Information about how to access the advocate was displayed around the ward. Staff did not provide regular opportunities for patients to feedback about the service. Due to staff shortages and time pressures, community meetings had not been held regularly.

Safe environments

Score

2. Evidence shows some shortfalls in the standard of care

Managers did not ensure that regular assessments of the ward environment were completed. High risk items such as a discarded towel and a bottle lid on were on the ward that could be used by patients to self-harm. This exposed patients to an avoidable risk of harm.

We toured the ward and observed that it was mainly clean. A room provided for patients to get hot drinks was dirty, and rubbish had been discarded where there was no bin available. A bathroom and 2 toilets were also not clean, with 1 having an overflowing bin.

Staff could not observe patients in all parts of the wards and outside space. However, the service had fitted convex mirrors and CCTV to monitor communal areas and used enhanced observations to support patients with additional risks.

The ward complied with guidance and there was no mixed sex accommodation. The service only admitted female patients.

Staff had access to alarms and patients had easy access to nurse call systems, however, one staff member told us there was not always enough alarms for everyone to have one. This increased staff anxiety should an incident take place and increased risk of avoidable harm to patients.

The clinic room was clean and fully equipped, although no cleaning records were available in the room as they were stored on an electronic system. There was an air conditioning unit

located above the examination couch that was leaking. We saw accessible resuscitation equipment and emergency drugs that staff checked

regularly. However, the resuscitation bag appeared messy and had no tag in place to secure items after checks were complete. Checklists were completed intermittently; we raised this with the provider who confirmed that this was recorded on an in house electronic system. When this information was requested from the provider, we were sent only a checklist confirming the check had been completed. We were not assured that regular itemised checks were being conducted.

There was a comprehensive ligature risk assessment and appropriate furnishings to mitigate risk. However, during our tour of the ward, ligature alarms were inadvertently set off by a staff member on at least 3 occasions. It was noted that on only 1 occasion did a staff member respond to this alarm. We also saw staff not responding to another alarm and staff responding but with no urgency. This increased risk of serious harm to patients on the ward.

Each patient had their own bedroom, which they could personalise. Bedrooms were mainly clean and some had ensuite facilities. Staff did not ensure that bedroom environments were clean and clear, 1 patients' room was extremely unkempt. Clothes were strewn across the floor and piled up, and high-risk items such as empty bottles and plastic bags were present. This put this patient at avoidable risk of harm and did not provide a therapeutic environment in which to receive safe and effective care.

Staff used a range of rooms and equipment to support treatment and care. The ward had a clinic room, and rooms that could be used for group work, art therapy and activities.

Safe and effective staffing

Score

3. Evidence shows a good standard of care

The service establishment staffing was 3 nurses and 3 healthcare assistants and additional staff were used when patients required 1:1 observations. There were 4 vacancies for registered nurses and 1 vacancy for a healthcare assistant. In the past 3 months bank or agency staff were

used 432 times to cover sickness, absence or vacancies.
Staff told us that incidents were difficult to manage due to there not being enough staff. One staff member we spoke with told us they were anxious if there was a serious incident as they did not feel there would be enough staff to support them with this. Staff told us that community meetings, getting patients' hot drinks and incident recording was not always possible due to lack of staffing.
At the time of inspection, the staff sickness rate was 17.2% in October 2025, 16.4% in November 2025 and 16.9% in December 2025.
Managers had calculated the number of nurses and healthcare assistants required. There was a daily staffing call where resources could be moved to cover when the ward was short staffed, however, staff we spoke with did not feel staffing was sufficient to deliver safe care.
Staff had mostly kept up to date with their mandatory and essential training. Overall, compliance was between 60% and 100%. There were 3 pieces of training with a compliance rate of less than 75%. The training programme was comprehensive and met the needs of patients and staff.
Managers gave each new member of staff a full induction to the service before they started work.

Infection prevention and control

Score

3. Evidence shows a good standard of care

Staff maintained equipment well and kept it clean.
Most ward areas and clinic areas were clean and well maintained, however, 2 toilets and a bathroom were not clean.
Cleaning records were mostly up to date and demonstrated that all areas of the hospital were regularly cleaned, however, some areas could not be cleaned due to inaccessibility, for example, 1 room was covered in patients' possessions.
Staff followed infection control policy, including handwashing, this was evident in the quarterly handwashing audit that identified 100% compliance. Hand gel was not available at the ward entrance; the dispenser was empty at the time of our inspection. Compliance levels for essential training in infection control was 67%. This fell below the expected compliance of 75%.

Medicines optimisation

Score

1. Evidence shows significant shortfalls in the standard of care

Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal) and did it in line with national guidance.
Staff did not regularly record or review the physical health of patients; 4 of the 7 patients' records we reviewed did not have side effects monitoring in place for medication they had been prescribed. Three of the 7 had no management plan for physical health, causing increased risk of avoidable harm to the patients.

Effective

Rating Requires improvement

Staff did not always assess the physical health of all patients on admission. They did not always develop individual care plans which were reviewed regularly through multidisciplinary discussion and were not consistently updated as needed.

The ward team had access to a range of specialists required to meet the needs of patients on the ward, such as nutritionists and occupational therapists. However, specialist staff were being utilised for enhanced observations, reducing the therapeutic input for patients that were on general observations.

Assessing needs

Score

2. Evidence shows some shortfalls in the standard of care

We reviewed 7 care records during the assessment.
Patients did not always have their physical health assessed soon after admission and this was

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not always regularly reviewed during their time on the ward.
Staff did not consistently develop a comprehensive care plan for each patient that met their mental and physical health needs. Some patients did not have an up-to-date care plan and did not always have a documented treatment plan in place. One patient did not have a care plan or any reviews in place following a serious incident regarding their physical health. This increased risk of serious and avoidable harm to patients.

Delivering evidence-based care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

Patients were admitted to the ward with a mental illness diagnosis. Care and treatment involved prescribing medicines and offering therapeutic activities. Psychology groups and interventions included talking, music and art therapy.
Staff ensured that patients had access to physical healthcare, including access to specialists when needed. Staff supported patients to attend the acute hospital for required treatment.
The team included a range of specialists required to meet the needs of patients in the service, including activity co-ordinators and occupational therapists. However, these staff were used to cover 1:1 observations at times.
Managers had identified the learning needs of staff and were in the process of delivering training specific to a patient group that was prevalent in the service at the time.
Staff used technology to support patient care, this included patients having a personal device to communicate with family and carers and tablets to record required observation records.
Managers mostly supported permanent staff to develop through yearly, constructive appraisals of their work. Between October 2025 and December 2025, appraisals were between 72.2% and 73.6% complete.
Managers mostly supported staff through regular, constructive clinical supervision of their work. Clinical and managerial supervision compliance was between 91.3% and 70.8% between October and December 2025.
Permanent staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. However, patients told us agency staff did not always appear to have the right skills to care for them, with some describing them as ‘disinterested’. The trust

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told us they had not used agency staff in the 6 months prior to our visit.

How staff, teams and services work together

Score

2. Evidence shows some shortfalls in the standard of care

Staff held regular, weekly multidisciplinary meetings to discuss patients and improve their care. At these meetings, staff reviewed the patients' progress.

Staff shared information about patients and any changes in their care, including during handover meetings. However, one staff member told us that comprehensive handovers were not always completed due to capacity pressures on staff. Nurses and healthcare assistants held a handover meeting at the start of each shift.

Information relating to care, help and support, advocacy access, activities, chaplaincy and spiritual care and feedback on care were displayed on the ward notice board for patients.

Supporting people to live healthier lives

Score

2. Evidence shows some shortfalls in the standard of care

Staff did not always identify patients' physical health needs and record them in their care plans. One patient was recorded as having physical health needs that would require monitoring and medication but had no update or support for these conditions noted subsequently.
Staff supported patients to live healthier lives – for example, through participation in a smoking cessation scheme.
Ward activities helped promote a healthy lifestyle for patients – for example a weekly physiotherapy session and weekly walking group.

Monitoring and improving outcomes

Score

2. Evidence shows some shortfalls in the standard of care

Staff did not consistently monitor patients' health, their mental state and well-being, with care plans and risk assessments being inconsistent for the patients we looked at. Staff did not always engage or interact with patients on enhanced observations. However, we saw some evidence of personalised care including staff supporting a patient to take part in art therapy. Staff used a recognised rating scale - Clinical Outcomes in Routine Evaluation (CORE)-34. This is a widely used psychological assessment tool that helps clinicians evaluate the effectiveness of treatment and monitor client progress.

Consent to care and treatment

Score

2. Evidence shows some shortfalls in the standard of care

Staff did not always assess each patients' capacity to consent to admission and treatment. Only 6 of the 7 patients records we looked at had a capacity assessment recorded.
In the records we reviewed, patient's views and wishes were not always recorded.
Staff sometimes engaged with patients' families, however, their views and contribution were not recorded.

Caring

Rating Requires improvement

This means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Kindness, compassion and dignity

Score

2. Evidence shows some shortfalls in the standard of care

Patients told us that staff did not always treat people with kindness, empathy and compassion. They told us bank staff did not always provide their name or engage with patients. They raised concerns around observations not being carried out correctly, including staff sleeping and using their phones, increasing risk of avoidable harm. They told us that they did not feel safe on the ward due to staff shortages and staff not noticing when patients had harmed themselves. However, some patients spoke highly of permanent staff on the ward.

Staff were able to give examples of personalised care for individual patients, and it was clear they knew their patients well.

A family member told us they felt staff on the ward were unprofessional and had concerns their relative was able to cause harm to themselves whilst on 1:1 observations. However, they spoke highly of the ward doctor, who was positive and supported patients to understand and manage their care, treatment or condition and explains things well.

At the recent Mental Health Act (MHA) review, the advocate for the hospital told us they provided a regular drop-in service. They provided support with section 132 rights and appeals. The advocate told us they were not provided with patients' risk information before they met them on their own and private meeting space was not always available causing them to have to use patients' bedrooms.

The service had a weekly chaplaincy visit to fulfil premade and ad-hoc appointments with patients. Religious materials were available at the request of the patient.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. All staff were confident they could speak up and raise concerns with leaders.

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Treating people as individuals

Score

2. Evidence shows some shortfalls in the standard of care

The service made adjustments for disabled patients – for example, by ensuring disabled people's access to premises and by meeting patients' specific communication needs.
Managers ensured staff and patients had easy access to interpreters and/or signers.
Patients had a choice of food to meet the dietary requirements of religious and ethnic groups and to account for allergies and intolerances.
The service was able to demonstrate considerations and actions taken to ensure person centred care was provided to patients with protected characteristics. This included staff supporting patients to obtain items to enable patients to practice their faith.

Independence, choice and control

Score

2. Evidence shows some shortfalls in the standard of care

Staff made sure patients could access information on their rights and how to complain. Up to date information about the Mental Health Act, advocacy, the Care Quality Commission and making complaints was displayed on notice boards on the ward. Patients were able to provide feedback to staff during community meetings; however, these were not taking place regularly. One patient told us they had written several complaints but had received no outcome from these.
Patients could make phone calls in private. Staff did not restrict patients access to their mobile telephones or devices.

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Responding to people's immediate needs

Score

2. Evidence shows some shortfalls in the standard of care

Patients were not always involved in their care plans and risk assessments and 2 patients we spoke with had never seen their care plan and did not know what was in it. The trust provided care plans after the inspection that evidenced staff were recording patient views, however, this was not evidence that patients were actually involved. Patients and their carers attended ward rounds, but not all felt they were involved in decisions about care, treatment and discharge.
Staff were not always aware of specific risks and did not always care plan for these accordingly.
Staff did not ensure that patients' risk had always been assessed satisfactorily. One patient was recorded as having a health condition that required regular monitoring and medication; however, this was not present in the care plan or risk assessment.
Staff did not ensure that a thorough risk assessment and action plan was completed in relation to a patient who could pose a risk of harm to patients and staff.
Regular community meetings were supposed to take place on the ward; however, staff and patients told us these did not regularly take place.
Staff made sure patients could access advocacy services. Information on how to contact the independent mental health advocacy service was displayed on a notice board.

Workforce wellbeing and enablement

Score

1. Evidence shows significant shortfalls in the standard of care

Most staff said the leadership team were approachable, supportive and engaged with staff on the ward. Staff and managers said they found senior managers at the hospital to be supportive.
The provider's staff sickness rate was between 17.2% and 16.9% throughout the months of October to December 2025.
The service recognised staff success and had a recognition scheme, which included positive feedback from the patients that was displayed on the ward, nurse of the month, staff member

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of the month, student of the month and staff awards. We also saw an opportunity for a staff member to win afternoon tea at The House of Lords.
Staff told us that morale on the team was low, they were burnt out and there were not enough staff at times to ensure the safety and wellbeing of all patients. They told us they were not always able to assist patients with getting them hot drinks and were unable to support with alarm response due to being on enhanced observations. This increased risk of serious harm to patients and put staff under additional stress when they were the only staff member free to attend alarms.
However, staff we spoke with felt proud of the strong team they had built on the ward. They told us that their work could be demanding but they enjoyed working within mental health. All staff we spoke with were passionate about helping the patients.

Responsive

Rating Requires improvement

Staff regularly met with patients in multi-disciplinary team (MDT) meetings to discuss patients' care and treatment. These discussions took place weekly and ward reviews were completed 3 times a week. Care plans and risk assessments were not always updated with any changes identified. Patients told us that 1:1 meetings with their named nurse did not always take place and not all patients knew who their named nurse was.

Staff monitored patients' conditions and discussed any changes at twice daily handover meetings. However, staff told us these were not always comprehensive due to low staffing numbers and lack of time allocated to them to complete administrative tasks.

Person-centred care

Score

2. Evidence shows some shortfalls in the standard of care

Staff regularly met with patients in multi-disciplinary team (MDT) meetings to discuss patients' care and treatment. These discussions took place weekly and ward reviews were completed 3

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times a week. Care plans and risk assessments were not always updated with any changes identified. Patients told us that 1:1 meetings with their named nurse did not always take place and not all patients knew who their named nurse was.

Staff monitored patients' conditions and discussed any changes at twice daily handover meetings. However, staff told us these were not always comprehensive due to low staffing numbers and lack of time allocated to them to complete administrative tasks.

Care provision, integration and continuity

Score

2. Evidence shows some shortfalls in the standard of care

Staff supported patients to maintain contact with their families and friends, this included patients having the use of mobile phones. Family members were invited to join MDT meetings. The service told us patients could access employment specialists who provided support to anyone interested in paid or voluntary employment, although we did not see any individual examples of this taking place.

Providing information

Score

2. Evidence shows some shortfalls in the standard of care

Staff made notifications to external bodies as needed. The service submitted notifications to the Care Quality Commission in accordance with the requirements of their registration. The service submitted safeguarding referrals to the local authority.
The service complied with the Accessible Information Standard. We saw various easy read documents that could be provided to patients.
Staff ensured that patients could obtain information on their rights and how to complain.
A welcome pack was provided on admission and this included details of a carers group that family members and carers could attend.

Listening to and involving people

Score

2. Evidence shows some shortfalls in the standard of care

Patients, relatives and carers knew how to complain or raise concerns. Information about how to make a complaint and how to raise concerns with the Care Quality Commission was available on noticeboards throughout the ward.
Staff knew how to acknowledge complaints and tried to swiftly resolve them with patients. In the last 12 months, managers received 8 complaints. All were documented as being addressed and 4 were ongoing.
In the past 12 months the ward received 2 documented compliments. These were from patients receiving care and were complimenting individual staff members.

Equity in access

Score

2. Evidence shows some shortfalls in the standard of care

Staff ensured the needs of patients with mobility issues were met – for example, a wheelchair user was accommodated during our inspection.
There was adequate medical cover, and the general hospital was located at the same site as the ward meaning staff could get prompt assistance in a medical emergency.
Staff planned for patients' discharge, including liaison with partners to arrange accommodation. Care plans identified discharge planning was in place from admission and regularly updated.
It was unclear from the data provided by the service, whether there were any delayed discharges in the past 12 months.

Equity in experiences and outcomes

Score

2. Evidence shows some shortfalls in the standard of care

The trust had a culture of care programme that included equality, choice and transparency. The service gave us examples of supporting transgender patients at the hospital.
Staff shared that adjustments were made to accommodate patients with diverse needs, including the use of a dietitian for a patient that required it. Information was available in alternative formats to ensure accessibility.
At the time of inspection, 100% of staff had completed training in Equality and Diversity.

Planning for the future

Score

2. Evidence shows some shortfalls in the standard of care

Staff did not always create personalised care plans to account for the patients' needs, wishes and feelings. Whilst these may have been discussed with the patient, and their family members, there was not always a record of this.
Patients told us that they were not always supported to make decisions about their care, treatment and future.

Well-led

Rating Requires improvement

This means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Shared direction and culture

Score

3. Evidence shows a good standard of care

Staff were mostly aware of the trust's values of 'we care, we learn and we empower' and mostly demonstrated these values in their day-to-day work.
The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.
Staff felt mostly supported by senior leaders who were visible and approachable. However, they did not feel the minimum establishment numbers for the ward enabled them to provide safe and effective care raising the risk of avoidable harm to staff and patients.

Capable, compassionate and inclusive leaders

Score

3. Evidence shows a good standard of care

At the time of the inspection there had been a gap in permanent leadership on the ward. Staff told us not having a ward manager was challenging and had a detrimental effect on them and their wellbeing. A newly appointed ward manager was present on the day of our inspection but had not had time to embed. A newly appointed matron had also started on the ward.
Staff told us leaders were visible in the service and approachable for patients and staff. However, due to low staffing they were taking on additional tasks such as enhanced observations. This highlighted significant gaps in the resources needed to provide safe and effective care, as well as a lack of therapeutic engagement during enhanced observations.

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Freedom to speak up

Score

3. Evidence shows a good standard of care

Patients and carers had opportunities to give feedback on the service they received, and a family member told us they received a response when they raised concerns. However, patients told us community meetings did not always take place as planned and their repeated concerns were not always addressed, for example the hot tap to make drinks was not functioning effectively.
The trust had a freedom to speak up guardian to support staff. However, some staff told us they had raised concerns regarding staffing and safety on the ward but had not seen changes to establishment numbers.

Workforce equality, diversity and inclusion

Score

3. Evidence shows a good standard of care

There were equality and diversity champions within the service.
There were Staff Equality Networks within the Trust, including Ethnic Minority and Race Equality Network, Disability and Mental Health, Faith and Spirituality and Lesbian, Gay, Bi, Trans and any other sexuality or gender identity group (LGBTQ+).
Staff were able to apply to work flexibly, for example, flexible working agreements to account for personal circumstances such as caring responsibilities and health issues.
Staff did not raise any concerns about discrimination; they told us that an example of racial abuse from a patient was handled appropriately within a community meeting.

Governance, management and sustainability

Score

1. Evidence shows significant shortfalls in the standard of care

Our findings from the other key questions demonstrated that governance processes were not always effective at team level and that risk was not always managed well. An example of this could be seen in the observation allocation policy not being followed.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However, staff did not always complete this in detail, for example, team training compliance was raised in manager's feedback, yet this was not referred to in actions/outcomes. This made it more difficult to maintain effective governance of outstanding actions ahead of subsequent team meetings.

We reviewed audits required for the trust, including Ardleigh ward. During October 2025, staff did not always comply with data submissions for the audits. For example, fire safety and health and safety audits were due to be submitted once a month. However, staff on Ardleigh ward had not made a submission for the last 6 months.

The risk register did not include all risks for the ward that were present. We were therefore not assured that all risks were recorded and monitored appropriately, causing increased risk of avoidable harm to patients.

The service had contingency plans for emergencies – for example, an outbreak of fire.

Staff had access to the equipment and information technology needed to do their work. The ward used the Electronic Prescribing and Medicines Administration (ePMA) system, the EPUT care portal where information sharing takes place and Oxivision, which was a contactless monitoring system in the bedrooms. This monitors heart rate, breathing rate, location and movement, without the need for physical contact.

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Partnerships and communities

Score

3. Evidence shows a good standard of care

Patients and staff could meet with members of the ward's senior leadership team to give and receive feedback.

Learning, improvement and innovation

Score

3. Evidence shows a good standard of care

Innovations were taking place in the service to make improvements, including the introduction of Registered General Nursing staff to the ward. This assists in a holistic overview when creating care plans for patients. The ward had recently recruited a permanent manager and matron to the ward to better support staff and patients.