

30 April 2026

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Care Quality Commission
Citygate Gallowgate
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Via email [redacted] [redacted]

Cc: [redacted] [redacted]

Dear [redacted] [redacted]

Re: Warning Notice received 05 February 2026 (Reference: ENF2-000000003785)

In response to the Section 29A Warning Notice issued on 05 February 2026 in relation to healthcare being delivered at 439 Ipswich Road, the Trust has undertaken a comprehensive review of the concerns identified and the requirements set out by the Care Quality Commission (CQC). The Trust recognises the seriousness of the concerns raised and has taken prompt and sustained action to address the identified issues.

Regulation 13, Safeguarding: Service users must be protected from abuse and improper treatment

1. Staff failed to report safeguarding incidents appropriately

The Trust has taken decisive action to address the safeguarding concerns identified at Ipswich Road. Safeguarding concerns have now been raised for all incidents involving the four identified patients, and Datix incident records have been reviewed and updated accordingly to ensure accuracy and completeness.

Safeguarding investigations continue to be led by the Trust Safeguarding Team, in partnership with the Local Authority to ensure robust oversight and effective multi-agency working. Immediate welfare checks were undertaken for all patients at Ipswich Road to provide assurance regarding their safety and wellbeing. In addition, an organisational safeguarding concern has been raised to ensure appropriate executive oversight and organisational learning.

Mandatory safeguarding training compliance has been reviewed and strengthened, with all staff at Ipswich Road now up to date with Level 3 safeguarding training. (Appendix 1. Ipswich Road Safeguarding Audit – Action 8) In addition to mandatory requirements, bespoke safeguarding and sexual safety training, informed by identified training needs, has been delivered to staff at the unit. Targeted workshops focusing on sexual safety and safeguarding have been completed, and a Clinical Specialist for Safeguarding attended the unit to engage with managers and staff. Ongoing support is now provided through regular supervision and drop-in support.

A safeguarding audit was undertaken on 26 November 2025 which found staff could describe the appropriate actions to take in response to a sexual safety incident or disclosure. (Appendix 1)

Safeguarding discussions have been embedded into community meetings (Appendix 2. Community Meetings), supervision, one-to-one support, and business meetings. (Appendix 3. Business Meeting 11.3.26 – Section 2.2) This provides staff with regular forums that encourage safeguarding discussion. The Safeguarding Team attendance at MDT meetings has been planned to support ongoing review and oversight and timely escalation of safeguarding concerns.

A Sexual Safety audit was undertaken by the Safeguarding Team on 26 November 2025 which found assurance against all indicators demonstrating that the actions outlined have supported an increase in staff understanding and confidence in safeguarding processes. (Appendix 1. Ipswich Road Safeguarding Audit). A repeat audit is scheduled for June 2026 to provide assurance that improvements are sustained.

2. From April 2020 to May 2025 there were 12 incidents reported about inappropriate behaviour and sexual safety concerns involving staff member A

A comprehensive case review has been undertaken in collaboration with the Trust Human Resources Team and operational services to explore how safeguarding concerns involving Staff Member A were managed. A detailed chronology has previously been shared with the CQC.

The review identified that concerns were initially managed individually at local management level. Subsequently, a collective review of all concerns was undertaken, resulting in the formal HR conduct processes being initiated. This process remains active.

Since April 2020, HR processes have been strengthened in line with the Dido Harding Review (May 2019) and MacIntyre Review (2024). Improvements include a strengthened collaborative approach between Safeguarding and HR throughout the process and enhanced oversight through Conduct Concern Panels. The Trust Disciplinary (Conduct) policy - HR27a has been reviewed as part of this process. (Appendix 4 – HPG27a)

The Conduct Concerns Panel was established in 2024 which includes leads from Safeguarding, EDI and an HR advisor taking a holistic oversight of the concern raised. The panel provides rapid review, response and decision making for any concerns raised where it could be considered that there has been a breach of Trust disciplinary conduct rules as set out in Trust Policy (HPG27a). Introduction of the panel has also increased independence on decision making.

Bespoke investigation training has been delivered to managers, and HR structures have been aligned to care units to improve oversight and reduce the risk of recurrence. HR coaching will be undertaken with the new leadership team in May 2026.

Regulation 17, Good Governance

(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

1. Managers did not have adequate oversight of staff. Supervision compliance was an average of 46% from May to October 2025

Since the CQC inspection, a new matron and ward manager have come into post and prioritised compliance with Trust expectations for regular supervision and appraisal.

Supervision compliance has significantly improved and is currently at 100%. (Appendix 5 - Supervision & Appraisal rates). Managers have prioritised regular one-to-one supervision, with a particular focus on the named nurse role. Compliance forms part of routine governance reporting and is actively monitored.

Appraisal compliance has also significantly improved to 100%. (Appendix 5 - Supervision & Appraisal) Appraisals are reviewed through governance processes alongside supervision compliance, with progress monitored through leadership oversight and quality assurance activity.

Care unit leadership and executive oversight of supervision and appraisal is undertaken through the monthly accountability framework meetings. These forums provide clear line-of-sight from service-level delivery to Executive leadership, enabling timely scrutiny, challenge and support where required. This has supported the new leadership at Ipswich Road in sustaining an improvement in Supervision and Appraisal.

2. There was lack of management oversight. There were gaps in clinical audits. For example, ward manager audits were not completed for 4 out of the last 12 months.

The Trust has strengthened governance systems following the inspection. A new leadership team has been embedded at Ipswich Road, with additional support provided to the new Matron and Ward Manager to improve day-to-day oversight, decision-making and assurance. Leadership presence on the ward has increased and staff engagement with leadership has improved. (Appendix 6 - QAV summary)

To ensure continuous monitoring and learning, systems for monitoring quality and safety have been reviewed and strengthened by the new leadership. This has included strengthening oversight of the ward audit programme (Tenable audits). Tenable audits are being consistently completed, with findings shared with the team and improvement actions implemented and monitored. (Appendix 7 - Tenable Audits).

The Tenable audit schedule provides assurance that the Ward Managers audit has been completed in full in February and March and shows an increase in compliance from 73.7% (October 25) to 96.6% (February 2026) and 88.6% (March 2026). We have also seen improvements in the MHA audit increasing from 71% (October 2025) to 83.8% (March 2026)

In addition, the Matron implemented a structured process to review the quality of record keeping. Good practice has been identified alongside areas for improvement which are being addressed through individual feedback and development.

The Matron has strengthened governance reporting, utilising business meetings to monitor audit outcomes. The Service Manager holds a monthly Leadership Meeting where areas for improvement are highlighted and these are fed into the Care Unit Governance and Accountability meetings.

The outcome of Ipswich Road audits, along with all inpatient wards, are presented to the Care Unit governance meeting to ensure appropriate action is being undertaken to address findings and share learning.

Through this process of quality audits, leadership meetings, and ongoing review of governance processes the Trust ensures improvement are made and sustained. This is further supported by Quality Assurance Visits to the unit.

(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

3. Managers did not have adequate systems in place to monitor the assessment of risk

Immediately following the CQC inspection, comprehensive clinical reviews were undertaken to ensure all patients had up-to-date risk assessments and updating of care plans. Where required, full multidisciplinary team (MDT) reviews were completed.

As part of the immediate review, conversations were held with every patient to discuss their current level of support and ensure they understand and agree with their risk management plans. In addition, families and carers were involved in care planning.

Following the immediate action taken, the unit undertook the Tendable person centred audit to further review patient involvement in risk assessment and care planning. (Appendix 8 - Person Centred Tendable Audit - 17.12.25 and Appendix 9 - Person Centred Tendable Audit - 12.02.26)

MDT discussions have been strengthened to ensure risks are discussed collectively and appropriately recorded. (Appendix 10 - MDT Minutes)

Risk assessment monitoring is also undertaken as part of the Tendable audit programme outlined above, this ensures ongoing oversight of patient risk assessment.

The admissions processes have been reviewed to ensure that future admissions have an immediate documented risk assessment undertaken.

Leadership assurance is provided through a structured and multi-layered assessment of patient risk, supporting effective feedback and learning.

Nurse in Charge (NIC) responsibilities ensure that required checks are completed at the point of patient admission, providing immediate assurance of risk assessment and management. The Live Clinical Dashboard enables real-time identification of immediate breaches, allowing prompt action to mitigate risk. This is complemented by a monthly performance report that systematically monitors and analyses breaches, supporting the identification of emerging trends, recurring issues, and areas requiring targeted improvement and management oversight.

Ongoing weekly checks further strengthen oversight, enabling early identification of any gaps in compliance and supporting continuous learning and improvement. Any gaps identified are formally highlighted through the Quality and Safety (Q&S) meeting, enabling timely escalation and action. Monthly managers' meetings receive consolidated reports, with assurance and learning fed through the Accountability Framework (AF), providing clear executive oversight and supporting continuous improvement in patient safety and risk management.

4. Managers did not have robust oversight of incidents

A retrospective review of all recent incident records (Datix) was completed to ensure that appropriate actions were identified and learning was captured. In parallel, the Safeguarding Team reviewed incident responses to confirm that incidents promptly trigger risk assessment and appropriate management actions.

Learning from incidents has been shared through team business meetings and across the Trust's Inpatient Care Units to support organisational learning.

Refresher training on Datix incident reporting has been supported by direct input from the Datix Senior Manager. Ongoing monitoring arrangements are in place to ensure reporting standards are maintained.

It was recognised that staff confidence in management response to reported incidents has been limited. To address this, a new Matron and Ward Manager have been appointed, with a clear focus on rebuilding trust, increasing leadership visibility, and creating a where staff feel confident to raise concerns. This supported by the Care Unit Leadership Team through regular engagement and oversight.

Immediate learning is actively discussed and shared through daily safety huddles, ensuring that emerging risks, incidents, or near-misses are promptly communicated to staff. This enables teams to reflect on issues in real time, reinforce good practice, and agree immediate actions to reduce the risk of recurrence. Safety huddles provide a consistent forum for open discussion, fostering a learning culture, improving situational awareness, and supporting timely feedback to staff to strengthen patient safety and quality of care.

5. Concerns relating to the health and safety of the environment were not effectively actioned, putting patients at risk of avoidable harm

The Trust has taken immediate and sustained action to address risks identified during inspection

A formal monthly environmental walkaround process has been implemented involving the ward management team and Estates colleagues. Site Managers maintain site logs documenting environmental and fire safety risks, with outstanding actions escalated and monitored through governance processes.

Admissions processes were strengthened to immediate and documented risk assessment. The unit Standard Operating Procedure (SOP) has been reviewed and updated to clearly define the role of the Coach House as a step-down environment supporting more independent living. The revised SOP is currently progressing through the ratification process. (Appendix 11 - Ipswich Road Mental Health Rehabilitation Operational Policy v.1)

(a) Large hole in garden fence, providing an opportunity for patients to abscond

The damaged section of the garden fence has been repaired following Estates review. (Appendix 12 - Estates Job - Fence)

(b) Fire risks were not appropriately identified or managed.

Immediate action was taken to remove the black bag covering the window on the fire exit door, and a full review of fire safety and storage practices was completed. Fire safety expectations were reinforced and cupboards have been clearly labelled to support safe practice.

The Pillow stored directly behind the washing machine was removed at the time of the CQC visit and the team reminded about fire safety. All cupboards have been given clear labelling to assist staff.

(c) Ligature risks were not appropriately identified or mitigated (unlocked shed, broken appliances in the garden)

Ligature risks were mitigated through securing the garden shed, removing broken or unsafe appliances and conducting follow-up environmental checks. Risk management relating to self-harm and suicide have been further strengthened through a review of patient risk assessments.

On further review was noted that the shed was no longer needed and this has been subsequently removed (Appendix 13 – Estates Job – Removal of Shed)

(d) Due to some patients not being assessed on admission their risk of self-harm and suicide was unknown and unable to be mitigated. There were no ligature cutters in the Coach House

Please see above response regarding risk assessment.

In line with Trust policy, ligature cutters are not stored in patient-accessible areas. The Coach House is a step-down environment supporting more independent living, with no restricted staff-only area, ligature cutters are brought to an emergency situation alongside the CPR grab bag. Emergency response procedures have been tested through simulation exercises (Appendix 14 - Ligature & CPR simulation drill)

(e) Cleaning liquids were not safely stored. We found cleaning liquid in a paper cup in a kitchen cupboard in the Coach House

The cleaning liquid identified was removed immediately. Patients at the Coach House are preparing for independent living with risks assessed for each individual. Additional environmental checks have been implemented to ensure safe storage of cleaning products.

(f) Managers did not enforce safety processes. Not all staff were wearing personal alarms. There were no alarms around the building in the event of an emergency

The Trust investigated concerns regarding the availability and use of personal alarms and identified shortages can occur linked to meetings activity on the unit. Additional alarms have been ordered and enhanced sign-in and sign-out processes implemented. Compliance is monitored through leadership walkarounds and quality assurance visits.

The Trust is assured that the actions outlined in this response have addressed the concerns identified in the Section 29A Warning Notice and have resulted in strengthened safeguarding practice, improved leadership oversight, and more robust governance arrangements at 439 Ipswich Road. Ongoing monitoring, audit, and leadership oversight are in place to ensure improvements are sustained and embedded.

Please do come back to us should you require any further information following your review.

Yours sincerely

[I/S]

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Chief Executive

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Ann Sheridan
Executive Chief Nurse

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Executive Chief Medical Director