



Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
www.cqc.org.uk

Essex Partnership University NHS Foundation Trust

For the attention of Paul Scott

Trust Head Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

Sent by email to: [I/S]
5th February 2026

Our reference: [I/S]
Account number: [I/S]

URGENT – PLEASE RESPOND by 12pm Friday 6th February 2026

Dear Essex Partnership University NHS Foundation Trust,

Possible Urgent Enforcement Action – Section 31 of the Health and Social Care Act 2008

I am writing to notify you of serious concerns which have been identified during the Care Quality Commission's inspection of Acute wards for adults of working age and psychiatric intensive care units at Ardleigh ward, The Lakes, Turner Rd, Mile End, Colchester CO4 5JL which began on 21 January 2026. On site visits formulate one part of the regulatory framework and virtual interviews and data analysis take place before and after this. Following further virtual activity concerns came to our attention which have been assessed as meeting the threshold for possible urgent enforcement activity.

The concerns relate to responding to incidents, enhanced observations, the environment, recording of incidents and staff handovers.

1. Responding to incidents

CQC staff witnessed alarms not being appropriately responded to. Staff we spoke with raised concerns that there is a lack of support for incident response from within the ward due to low staffing, making them feel unsafe. During a pre-arranged remote interview with a staff member, they were the only person available to attend alarms, causing them to leave the interview numerous times. Between 1/12/25 and 21/1/26 there were 37 incidents of deliberate self harm which demonstrates the frequency of incidents happening and the potential for missed opportunities to prevent harm. If incidents and alarms are not appropriately responded to this can result in significant avoidable harm.

On 14/1/26 a choking incident required CPR causing broken ribs to the patient. Staff did not record the cause of the choking incident and did not review a risk assessment post incident to identify ways to prevent reoccurrence. The trust has not yet provided the risk management plan referred to in the patient's notes. Failure to properly assess and plan regarding the risk of choking is likely to place patients at risk of ongoing and avoidable harm.

On 31/12/25 a patient ligatured causing discoloration to the face. Records indicated they expressed thoughts of self-harm being present all day prior to the incident. The patient remained on Level 2 observations until 1500 when Level 3 observations were due to commence, as per plan. One patient told us there were only 3 members of staff on shift for 18 patients and another told us there were only 4 members of staff on this date. The trust have not yet provided requested data for us to assess if patient observations were planned in line with staffing numbers or patient risk. Failure to undertake observations based on risk to patients causes risk of ongoing and avoidable harm.

2. Enhanced observations

Managers allocated staff to enhanced observations for more than two hours consecutively. This does not align with best practice guidance. On 16/01/26 a member of staff was on enhanced observations from 0730-1230 and then 1430-1730. A patient at Colchester General Hospital (who resided on Ardleigh but was receiving treatment) on 17/01/26 had the same staff member on observations between 1930-2230 and 0130-0430. Enhanced observations for this extended period can cause risks of excessive tiredness and lack of vigilance of staff. This has a detrimental effect on providing safe and effective care and exposing patients to ongoing and avoidable harm.

3. Environmental concerns

A milk bottle lid was used by patients to stop the water escaping the bath in the absence of a plug. Whilst the ward now had a plug, the lid had not been discarded. On 02/12/25 a patient took bottle lid off a bottle from the bin and ingested it requiring back slaps and abdominal thrusts from staff. With a patient on the ward with risks of ingesting such items this poses a risk of avoidable harm.

A dirty towel was discarded in a communal area accessible to all patients, some at risk of self-harm. There were 20 incidents of ligature (self-tying not from an anchor point) between 01/12/25 and 21/01/26 and this item increased the risk of avoidable harm.

The bedroom of a patient was extremely unkempt with high-risk items such as plastic bags and empty bottles present. The presence of these items raises the risk of serious avoidable harm.

Staff failed to identify and mitigate the risks posed by these items meaning patients were exposed to avoidable harm.

4. Recording of incidents

During our assessment staff told us they cannot always record incidents due to having no time for administration. The failure to appropriately record incidents creates missed opportunities for learning and oversight, does not produce accurate data for analysis and increases the risk of avoidable harm to patients and staff.

5. Staff handovers

During our assessment staff told us that handovers are not always comprehensive due to lack of time and staff are recalling information from memory, which may not always be accurate and complete. Failure to adequately handover patient information increases the likelihood that risks are not being appropriately assessed and mitigated, putting individual patients and others at risk of avoidable harm.

Action which the Commission is considering

The Commission is currently considering whether to use its powers pursuant to the urgent procedure (for suspension, or imposition or variation or removal of conditions of registration) under Section 31 of the Health and Social Act 2008.

Section 31 allows the Commission to serve a Notice of Decision upon you if it has reasonable cause to believe that, unless it acts any person will or may be exposed to the risk of harm. Such a notice would suspend your registration for a period of time, or impose, vary or remove conditions on your registration with immediate effect.

What you need to do - action plan (with timeframes)

The effect of using Section 31 powers is serious and immediate. When considering the use of these powers, the Commission can offer the registered provider the opportunity to put forward documentary evidence which may provide assurance that the risks identified have already been removed or are immediately being removed. You now have an opportunity to put forward documentary evidence to reassure us that the risks have been removed or are immediately being removed.

The Commission therefore invites you to complete and send urgently an action plan, setting out how either you have already addressed each of the concerns identified above, or how you intend to address them immediately. As part of your action plan, you should set out a specific time frame for implementing each action and who will be doing it. You may include documentary evidence supporting any actions taken or intended.

In light of the seriousness of the issues at hand, the Commission advise that you should consider obtaining legal advice in relation to this matter.

You must submit your action plan by **Friday 6th February 2026 at 12pm** by email to

[I/S] and [I/S]

Areas which your action plan must address

1) Responding to incidents

You must provide a detailed action plan (with supporting evidence) which details how concerns raised about responding to incidents will be addressed.

2) Enhanced observations

You must provide a detailed action plan (with supporting evidence) which shows how you will support staff and ensure that observations are not in excess of two hours consecutively.

3) Environmental concerns

You must provide a detailed action plan (with supporting evidence) which details the concerns raised have been addressed and what is being put in place to prevent further risks occurring again.

4) Recording of incidents

We require you to provide us with what actions, systems and policies you have put in place (with supporting evidence) to ensure the robust and timely

recording of all incidents, including how appropriate action will be taken with applicable timescales.

5) Staff handovers

How you will ensure there are effective systems in place to ensure all handovers are thorough and comprehensive including systems and governance around this.

What we will do with your action plan

We will consider the action plan and decide what enforcement response is required.

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

Telephone: 03000 616161

Email: HSCAfurtherinformation@cqc.org.uk or

Write to: Care Quality Commission

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA

If you contact us, please make sure you quote our **reference number** at the top of this notice, as it may cause delay if you are not able to give it to us.

Yours sincerely

[I/S]

Victoria Green
Operations Manager