Independent Review of Greater Manchester Mental Health NHS Foundation Trust

Final Report, January 2024

Important note:

This is a detailed report which contains information about mental health care and treatment which some people may find distressing. This report also contains non-attributable direct quotes and feedback from some of the people who have been in receipt of those services under review. Whilst we have made every effort to limit the use of descriptive or distressing content, it was deemed necessary to include some of this information to place an emphasis on certain findings. We advise strongly that, if you might find some of this information triggering, you are supported to read this report in a safe way.

An 'easy read' version of this report is also available.

Foreword

In September 2022 the BBC broadcast the current affairs programme Panorama. The programme showed appalling levels of abuse, humiliation and bullying of patients at the Edenfield Centre in Prestwich, which is part of Greater Manchester Mental Health NHS Foundation Trust (GMMH). The horror of what was shown could not fail to touch anyone who watched the programme. In response to the concerns identified by BBC Panorama, NHS England subsequently commissioned this independent review to understand what took place, how and why. We were also asked by NHS England to look at other areas of concern regarding the quality of care within the Trust.

From the outset I want to say thank you to the patients, families, staff, and other interested and involved parties who gave their time so freely to me and my colleagues. As a review team we felt that most spoke with absolute candour about their experiences of Edenfield and GMMH. I am certain that without people speaking so freely and openly, the true extent of what took place may not have been known. When talking to people we hoped to create a space in which they could speak safely about their experiences. We wanted to listen appreciatively, and endeavoured to understand what was being shared with us. Perhaps not unexpectedly, many people became upset when sharing their experiences. What did surprise us was the level of distress displayed by so many GMMH staff.

As a review team we firmly believe that the vast majority of healthcare staff come to work to do a good job. Most of the staff we spoke to appeared committed to delivering compassionate care to those who needed their services. We wanted to understand what had gone so badly wrong, why this might have happened and to reduce the possibility of this happening again; not only in GMMH, but also in other organisations providing similar services. The need to achieve this learning was important for the review team. The NHS has experienced numerous opportunities to learn from adverse events. Reports are written, recommendations made, but this does not always lead to sustained improvement. We hope that our approach to this review may create an opportunity for improvements that will make a meaningful impact to the people the NHS is there to serve.

We have tried to write a report that feels human, is less technical, and that tries to capture the experience of what it was like to receive and provide care in GMMH. Throughout our work, we have tried to describe what the reality of care is like, versus care 'as imagined' by the Trust. Some patients and families described not being believed when they raised concerns or complained about the care received. We were told that they sometimes experienced unkindness, a lack of compassion and respect, and abuse by staff. Others shared how they did not always feel safe to disclose concerns, with many accounts of feeling intimidated, undermined, ignored, or fearful that 'bad news' was not welcomed. Sadly, we heard from many staff who said they were once proud to work for GMMH and that this had diminished over recent years. Within the timetable that was set for us by NHS England, we met over 400 people.

This report identifies what was happening across the Edenfield Centre and the broader Trust in recent years. We found a Trust that was not sufficiently focused on understanding the experience of patients, families and carers. Our interviews with senior staff, as well as our review of Board papers, found that the GMMH Board, while having many competing objectives, focused more on matters such as expansion, reputation and meeting operational targets rather than the quality of care provided. This led to insufficient oversight of the quality of care, with the Trust relying disproportionately on the periodic opinions of external regulators, rather than forming its own views based on strong governance. We found that there was insufficient curiosity about the ongoing patient and staff experience across the Trust. The lack of both curiosity and focus on improvement led to missed opportunities for organisational learning across a number of services.

As with many organisations nationally, we found a Trust that was facing significant workforce challenges; however, many staff described feeling exasperated, tired of not being listened to and disconnected from the Trust leadership. We were told that these concerns started long before the scope of this review. We heard that staff have felt fearful to speak up for many years, and that the full extent of Edenfield's nursing shortages and their consequences have been masked and ignored. Over time, this culture and way of working have led to many staff from across various disciplines leaving the organisation. Nursing levels had become unsafe; the ability to deliver safe and timely care was severely compromised. The inadequate governance systems and the wider Trust culture contributed to the purported 'invisibility' of these deteriorations. We found it was difficult to discern how this workforce crisis was acknowledged in GMMH: there was an absence of an effective response to these concerns. We also observed that some of the concerns identified within Edenfield existed across other parts of GMMH inpatient services.

We make several findings and recommendations that we hope will ensure learning will take place, enabling a sustainable approach to quality across the Trust. We also make some recommendations for the external partners whose role should be to support and challenge the Trust. In making these recommendations we are informed by the voices of the people who spoke so passionately about what must happen to ensure improvement. We met with many talented and dedicated staff who told us they want to work in an organisation that values people and the quality of care. They want to ensure they can meet the needs of the communities they serve and, in doing so, feel supported by the Trust. We have seen some signs that GMMH has started to focus on improvement, and this is encouraging. This will need to continue and will require a relentless focus on the quality of its services to maintain the progress that is needed.

I want to give thanks to the team that worked alongside me and who worked so diligently in trying to give voice to the truths we heard. I want to again thank all the patients, families, carers, and staff who shared their experiences with the team; without them this review would not have been possible.

Professor Oliver Shanley OBE

Final Report – 12 January 2024

This Final Report has been written in line with the terms of reference as set out in Appendix 1 of this report. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out of date. Our report has not been written in line with any UK or other (overseas) auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review, and therefore cannot attest to the reliability or accuracy of that data or information.

This is an independent report which has been prepared for NHS England and has been written for the purposes of publication. No other party may place any reliability whatsoever on this report, as this report has not been written for their contractual purposes.

Different versions of this report may exist in both hard copy and electronic formats, and therefore only the final signed and dated version of this report should be regarded as definitive.

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Chapter 1 Executive summary

1.1   In September 2022 the BBC broadcast their current affairs programme Panorama which showed evidence of the most shocking abuse and poor care of patients within the Edenfield Centre in Prestwich, Greater Manchester. Patients were humiliated, bullied, and verbally abused. The Edenfield Centre is a mental health medium and low secure service, supporting patients with a range of complex needs. Section 3.15 onwards describes the nature of services provided at Edenfield. The centre is part of Greater Manchester Mental Health NHS Foundation Trust (GMMH).

1.2   In November 2022, NHS England commissioned an Independent Review of the Trust. The review was asked primarily to focus on what had happened at Edenfield, but also to consider if similar concerns could be happening elsewhere in GMMH. Furthermore, the review was to determine how the broader healthcare system that is there to support the Trust had let concerns at Edenfield, and in other services, go either unnoticed or without a sufficient response.

1.3   We wanted to ensure our review was grounded in the reality of patients, families, carers and staff. We spoke to over 400 people during the course of this review. What was striking was the level of distress we found among patients, families and staff. Most of our conversations prompted some level of upset and stirred up very difficult memories for people. We thank them unreservedly for their contribution to our review. Given the distress that some people were experiencing, we asked GMMH to revisit what emotional support was available for staff. We also arranged with NHS England and the Integrated Care Board (ICB) for the Greater Manchester Resilience Hub to provide support for families and carers for those who expressed a need for additional support.

1.4   Patient care at GMMH has, at times, been poor, and the work of BBC Panorama has made this very clear. In some services, patients have been denied basic dignity and their human rights. At the same time, we also encountered a great many members of staff who were passionate, evidently talented and highly committed to their patients. It has been our task throughout this work to hold both of these facts in mind, and to remember that both of these things can co-exist. For the Trust to move forward and improve for its patients, these committed and passionate staff will need to be assured that things can change, and that the leadership of the Trust wants to make this happen.

1.5   We wanted to ensure that we placed patients, families and carers at the heart of this review. In Chapter 4 we describe what they told us. We have concluded that a large part of what was exposed through BBC Panorama was due to the lack of value placed on the patient's voice in GMMH, as well as a frequent disregard for the experiences of families and carers. It is clear that patients and their loved ones had raised, on various occasions, serious concerns about the care provided at Edenfield and elsewhere in the Trust, and that this had not aways been taken seriously. At all levels of the organisation, we struggled to see how the patient experience had been embedded into structures and processes, so that Trust leaders had a clear picture of how people who use their services experience care.

1.6   Patients at Edenfield are vulnerable. They are in a locked setting, away from the people most important to them and are typically detained under the Mental Health Act. This creates an inevitable disconnect for those patients and this was made much worse by COVID-19 and subsequent responses to the pandemic. This should have meant that special efforts were made to ensure that their voices were heard and respected, but this did not occur. Most people we spoke with, including those charged with oversight of the Trust, recognised this and reflected that the only way to stop this from happening again is to build patients' feedback about their care into the core of governance and regulatory processes.

1.7   Within the Trust, there were repeated missed opportunities to act on concerns raised at Edenfield. This included, for example, National Staff Survey results, information relating to levels of restrictive practice[1], a cultural audit in 2019 which raised concerns, staff vacancies, the instability of ward management and high consultant turnover. The almost complete absence of other intelligence,

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[1] Restrictive practice limits a patient's movement or freedom in order to keep the patient or others safe (Mental Health Act Code of Practice, 2015)

including safeguarding referrals and concerns raised, was also something which could and should have been explored. Poor leadership visibility[2] in the service, as well as weak governance processes and a practice of suppressing 'bad news' in the organisation, enabled this to happen.

1.8   We found a service that had all the hallmarks of a closed culture, including an absence of psychological safety,[3] incivility between staff, poor leadership, and a lack of teamworking. These conditions allowed what we saw on BBC Panorama both to happen and to go unchecked. The extent to which the Board has recognised this is variable, and in some cases, limited. We do not know the extent to which similar issues may be happening in other forensic services in England, particularly due to their 'locked' nature.

1.9   In Chapter 5 and Chapter 6 we discuss the leadership and culture of GMMH respectively. We know that the 'tone' of an organisation should be set by the board of directors and the executive team. We heard that the Board itself has been disconnected from the reality of what it was like for patients to receive, and for staff to deliver, care at GMMH. Board members had been visible in few services and Edenfield in particular, despite the high-risk nature of services delivered there, was a blind spot for the Board. During our review, we heard that the interim CEO and interim Chair were now seen often in the organisation, which was welcomed. The interim Chair was mentioned as being seen regularly at Edenfield.

1.10   During our fieldwork and within our terms of reference timescale we found that there has been an insufficient focus on quality, which was in part driven by the growth of the organisation. We heard that the expansion of the Trust had not seen a corresponding investment in quality oversight, and many staff said that since the acquisition of services, there has been an insidious decline in quality across several parts of the Trust. We were told by several Board and Executive Team members that both groups were concerned about their reputation, and that this had impacted on the transparency of what was shared both internally and externally. We heard that healthy debate and challenge had been discouraged, and that information provided to the Board was often poor and provided insufficient or inaccurate information to underpin Board assurance. The executive team did not work well together, and this was most notable between operational services and clinical leaders. The value, ability and effectiveness of the clinical voice was minimised or ignored. Within this vacuum, the operational voice became dominant, and the executive team and the board of directors allowed this to happen and made no effective intervention to address this.

1.11   A number of the Trust's leaders have lacked compassion and empathy. We heard repeated stories of senior managers treating staff poorly and fostering a culture of fear and intimidation in order to maintain performance standards. Staff throughout the organisation and at all levels gave us examples of how the clinical voice and quality of care suffered directly as a result of this. Several leaders identified by staff as displaying these behaviours remain in senior and influential posts; our review found that some of these individuals do not appear to understand how their behaviours might have contributed to the problems at GMMH. The Trust has commissioned separate independent investigations into some of these HR matters, and some of these investigations remain ongoing at the time of writing. That said, many staff are dismayed to see some of these individuals still in very senior roles. It is crucial that the Trust assures itself that all of its leaders are consistently role modelling the values and behaviours needed, to confirm that the Trust truly understands the impact of some of its leadership behaviours on staff and patients.

1.12   Diversity, in its broadest sense, has been lacking. We found that leaders had not received effective leadership development support, particularly in relation to values-based leadership styles. Many senior leaders in the organisation have spent the majority of their careers at GMMH and in its predecessor organisations. As such, some have a narrow experience of different leadership styles and ways of doing things. Several spent a significant part of their career working at Edenfield.

1.13   Making positive changes in all of the areas outlined in the chapters on Culture and Leadership is essential and we consider the importance of the workforce in enabling these changes in Chapter 7.

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[2] Visible leaders make efforts to spend time with, get to know and engage their staff.

[3] Psychological safety is "a shared belief held by members of a team that it's OK to take risks, to express their ideas and concerns, to speak up with questions, and to admit mistakes — all without fear of negative consequences." (Harvard Business Review, 2023).

The enormous workforce challenge in the NHS is well known, and GMMH has had higher vacancies than the national average in some professional groups, notably nursing and medicine. The workforce information the Board received was insufficient and there was not a clear strategy to address either the recruitment or retention of staff. The reports that were presented to the Board on inpatient nursing staffing levels were vague, overly optimistic, and often contained information that did not reflect the reality for inpatient services in GMMH. Encouragingly, we have seen improvements in the Safe Staffing Report to the Board.

1.14   Prior to BBC Panorama, and until interventions were taken, at Edenfield it was not uncommon for a single qualified nurse to have to assume responsibility for three wards. We heard of newly qualified nurses taking on leadership roles that they were ill equipped to deal with, often with little practical support or supervision. We heard of high levels of turnover across all disciplines, but especially among consultant psychiatrists. These workforce pressures likely had a significant impact on the safety, experience and effectiveness of the care provided.

1.15   We heard that relationships across the consultant medical body were poor, and the impact of BBC Panorama led to a further deterioration in relationships. This had a significant adverse effect on their ability to provide the leadership and direction that the service required. We were so concerned about the distress of the doctors that we escalated this to the interim Chair and former Chief Executive of GMMH. We had also previously raised our concerns about the level of general distress across the workforce, the possibility of trauma, and the need for greater support for staff.

1.16   To enable GMMH to move forward it is imperative that it pays a much greater attention to the value and importance it places on its workforce, including the compassion shown towards them. This must be underlined by clear unambiguous information to the Board that sets out the impact of the workforce challenges and what this means to provide and receive care in the Trust.

1.17   In Chapter 8 we consider the effectiveness of the governance within GMMH. The Trust's governance framework failed to identify and escalate the issues presenting in Edenfield, to enable them to be surfaced and dealt with in a timely way. The information that was submitted to those Board subcommittees charged with quality and workforce was insufficient to provide assurance in these areas. We heard that reports presented to Board subcommittees would sometimes undergo various iterations before being presented to non-executive directors. It was not always clear what the rationale for these changes was, but there were occasions where the lack of information finally presented would have undoubtedly impacted on the ability of the non-executive directors to understand fully the extent of concerns.

1.18   We also witnessed missed opportunities to challenge or interrogate relevant data presented, which might have enabled more robust debate around quality concerns. The Trust has restructured its governance framework, and it is critical that the new model and processes enable concerns to be identified, acted on, and learned from quickly when things go wrong. This will involve ensuring that information can flow readily through the organisation, which is also contingent on developing a culture of openness and willingness to learn and improve. It is essential that this is done in a culture of transparency which, at times, appears to have been lacking.

1.19   A key determinant of how effective an organisation's governance is, is its ability to respond and learn when things go wrong. The provision of healthcare is complicated and has various inherently high risks. This is why learning and a commitment to improving are essential. In Chapter 9 we wanted to assess this in a concrete way. We therefore chose a small number of case studies to look at, where clear concerns had been raised. We looked at:

- how the organisation (and its partners) responded to concerns raised by a patient in its secure services;

- inpatient deaths through suicide, and the extent to which the organisation was responding to, and learning from, these tragic events;

- how the Trust has responded following the death of a person in its inpatient care, and;

- the Trust's improvement plan, and how well this enables learning.

1.20   We found some commonalities in the Trust's management of significant concerns being raised to them. These included:

- **A slow pace of change** – Some of these issues are very long-standing, have been known about for a long time and yet improvements are difficult to identify.

- **A lack of transparency and/or clarity in reporting** – Across three of the case studies we found that management information (whether in the form of incident reporting, quality metrics or board/committee reporting) has been opaque. In all three cases we looked at, it was difficult to get to the heart of the issue, or what had actually happened.

- **A lack of scrutiny of key information** – We found a need for more effective scrutiny of information presented to key forums (including sharing this with clinicians at an early stage), and a clearer and more coherent response from management and executives to challenge posed by non-executive directors. Openness and transparency are critical conditions if the Trust is to create a culture conducive to improvement and learning.

- **A lack of rigour in the monitoring of change** – There has been a tendency for the organisation to be overly optimistic in its reporting of changes made since all of these events. An example of this is the auditing of observations in child and adolescent mental health services (CAMHS) (see Chapter 9).This has, on some occasions, been challenged by senior staff or non-executive directors in the organisation, but we also found examples of key information being missed, which would suggest that existing plans are not having the desired impact and may be putting other patients at risk of harm.

1.21   As part of our assessment of organisational learning, we also reviewed the Trust's improvement plan. This showed a positive commitment to organisational change. We were concerned, however, that the improvement plan is driven by inputs and processes, and the Trust is trying to make a great many changes as quickly as possible. In reality, in its current form, the improvement plan is proposing simple solutions for what this review has found to be highly complex problems. There is an insufficient focus in the plan on the cultural and leadership changes needed in the organisation, which are crucial to ensuring that everything else can work well. These things are much harder to change, take longer to embed and are more difficult to measure.

1.22   As well as considering organisational learning we wanted to know whether similar concerns found in Edenfield about quality, safety and staffing existed elsewhere in the Trust. We explore this in Chapter 10. At Edenfield there were a number of factors that enabled the poor care and abuse to take place. These included:

- patients, their families and/or carers not being listened to or taken seriously;

- a weak and fragmented clinical voice;

- unsafe levels of staffing and high use of temporary staff;

- a poor physical environment;

- poor culture, including a lack of psychological safety and low morale, including unsupportive leadership behaviours, unsound HR practices including perceived unfair recruitment and promotion, and a lack of transparency about formal investigations;

- conditions leading staff to not adhere to clinical policies such as record keeping and observations; and

- some staff described being treated unfairly because of a protected characteristic.[4]

1.23   We wanted to understand if this could happen elsewhere in the Trust and undertook a high-level review of three areas: an acute adult inpatients site, an older people's inpatient site, and the child

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[4] These are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. (Equality and Human Rights Commission).

and adolescent mental health services (CAMHS) inpatient service. We selected these areas due to publicly available information regarding quality concerns.

1.24 It was clear that these services face some significant challenges, many of which are reflective of those we found at Edenfield and could potentially lead to similar outcomes for patients. In some of these services we found indicators of closed culture environments. Staffing is low at all of these sites, some have low morale, and we found evidence of staff being discriminated against based on race and ethnicity. In this part of the review, we have not been able to fully assess the scale of the risks in these services and make a recommendation about further work to determine their safety and quality.

1.25 In seeking to understand what happened within GMMH, it was essential to also look at the effectiveness of the governance processes of those charged with oversight of the Trust. GMMH does not work in a vacuum and those who commission and regulate services also have an important obligation to the patients and people they serve. In Chapter 11 we look at the system response, what partners knew and what they did. We believe there were some missed opportunities for the system to have supported GMMH at an earlier stage in response to various quality concerns that were emerging from the Trust. A timeline of key events, as well as a supporting detailed chronology, is set out at Appendix 5.

1.26 This was almost certainly impacted by these organisations recovering from the pandemic and being part of wider structural and legislative changes within the NHS. That said, the potential impact of change on quality is well known, and this was not paid sufficient regard. There were many indicators that the culture, safety and patient experience in Edenfield and elsewhere in the Trust were poor. These, as well as feedback from external reports, and inquest findings, were not identified, pieced together or acted upon by those charged with oversight and regulation of the Trust. It is clear that the usual protocols within each oversight or regulatory body for identifying a service in distress sufficiently early have not worked well enough.

1.27 System partners in Greater Manchester have, at times, relied on the opinion of the Care Quality Commission (CQC) without corroborating this with their own opinion, based on strong quality governance processes. We were left unconvinced that regulators and commissioners of GMMH have sufficiently strong structures in place (as well as the necessary mental health expertise) to have a clear understanding of existing and emerging risks in the Trust. Leaders of these organisations need to reflect on this with openness and humility to ensure that this does not happen again and ensure genuine learning takes place.

Conclusion and recommendations

1.28 The Trust and its partners have placed significant resource into improving GMMH services following the BBC Panorama exposé. Those charged with doing this at GMMH are working in a difficult environment; its executive team has several important gaps, many of its key leaders are in temporary roles, its workforce is depleted, and morale is low. There is also significant (and justified) scrutiny of the organisation from many stakeholders. These are difficult circumstances for those trying to make the necessary changes to work in, and those charged with overseeing the organisation need to be mindful of this.

1.29 Making change is, nonetheless, fundamental to ensure that the Trust can rebuild, retain its many talented and committed staff, and provide better care for its patients. Values-driven and transparent leadership, strong structures and processes, and a joined up and supportive system response are what is now needed for the Trust to deliver this.

1.30 We make a number of recommendations in this report that we hope will lead to positive change; these are outlined in Chapter 12. We have been struck throughout our review by the candour and bravery of the patients, families and carers we listened to. We also recognise how difficult this has been for so many GMMH staff. We noticed the very high levels of distress in many of those we heard from. We thank them for all of their support in enabling our review to take place and hope that this report has provided assurances through our findings and recommendations to enable a more positive and safe service.

1.31 The Trust is aware that it has a significant amount of work to undertake to improve, and this is reflected in the scale and breadth of its improvement plan. We have intentionally focused our recommendations on the areas in which we think that the most impact can be made over the next 12 to 18 months. We have tried to group these thematically, rather than making a high number of narrower recommendations, which are likely to overwhelm an organisation which is already working under high levels of scrutiny and without the right leadership and delivery capacity.

1.32 We also seek to address the cause of problems we have identified, rather than their impact. The problems we have identified are long-standing and will not be fixed by easy tasks. Rather, the Trust and its partners now need to address the underlying issues, so that they can make sustainable changes for the benefit of patients and staff. In implementing our recommendations, a fundamental component will be supporting GMMH in continuing to create a culture of improvement. This will not happen overnight, and stakeholders and partners will need to work alongside each other in enabling GMMH to thrive.

Chapter 2 Introduction

Background to this review

2.1   In November 2022, NHS England commissioned an independent review of Greater Manchester Mental Health NHS FT ('GMMH', or 'the Trust') which was led regionally by NHS England North West. This was done in response to failings in care given to patients at the Edenfield Centre in Prestwich in Salford. Professor Oliver Shanley OBE was appointed as Chair of this independent review in January 2023.

2.2   On 28 September 2022, the BBC broadcast a programme (Panorama) (BBC, 2022) which shocked and saddened those who watched it. An investigative journalist had worked in an undercover capacity in a care support role for some months at the Edenfield Centre. The Edenfield Centre provides forensic mental health services for men and women. It provides assessment, treatment and aftercare for people with complex mental health needs, many of whom are transferred from within the criminal justice system, or whose care and treatment needs cannot be met in other mental health services. This is usually because they are considered to have behaviours that put others and themselves at serious risk of harm.

2.3   The programme showed patients being abused, physically and emotionally by some members of staff. Patients were mocked, restrained inappropriately, and secluded for long periods. Staff were seen swearing, acting in an uncaring manner to and about patients, and sleeping during their shifts.

2.4   Following the broadcast of the programme, the Trust and NHS England took a number of actions:

- NHS England North West put in place a Rapid Quality Review to prioritise support and take immediate actions to improve patient safety.

- The unit was immediately closed to new admissions and remains so at the time of this report being published.

- Some affected patients were moved to other hospitals.

- Many staff were suspended, and some were ultimately dismissed from the Trust.

- When the Trust was placed in Segment 4[5], NHS England sent support teams in to help the Trust to improve.

- The Trust Board commissioned its own independent reviews to discover how this was allowed to happen.

- GMMH moved a number of patients who were not directly involved in the programme to facilitate ward closures and enable the redistribution of staff to ensure progress on safer staffing.

2.5   A police investigation into what the undercover reporter saw, some of which was shown on BBC Panorama, remains ongoing.

Terms of reference

2.6   The terms of reference for this review define what the review team (described as 'we' throughout this report) was tasked with looking at. These are described in full at Appendix 1. We spent six weeks consulting with various people affected by what was shown in BBC Panorama to agree what the focus of this review should be. This included conversations with:

- Patients and their families and carers

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[5] The national Recovery Support Programme (RSP), provided to all trusts and integrated care boards (ICBs) in segment 4 of the NHS Oversight Framework 2022/23 was launched on 13 July 2021. Organisations are placed in one of four 'segments' with four being the lowest performing, and defined as 'Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support' (NHS England).

- The families of two young people who died while in Trust inpatient services in 2020

- Patient groups

- Trust staff

- Trust commissioners (those who fund GMMH)

2.7 The views of these parties, together with feedback from NHS England and our own experience, resulted in the following terms of reference:

1. An independent assessment of what has happened within the Trust's secure services to identify conclusions and lessons. This assessment will ensure it identifies the actual reality of care for patients and staff.

2. An assessment of the culture, leadership, workforce planning and governance that may have impacted on the ability of the Trust to improve patient safety, treatment, and care, including how the Trust involved patients and families. This will include observations on culture that may have led to failures in professional standards.

3. An assessment of the adequacy of the actions taken by the Trust since the concerns were raised. This will include whether the Trust can demonstrate broader organisational learning to improve the quality of its services.

4. The review will consider whether the processes, actions, and responses of regulators, local commissioners, NHS England's Specialised Commissioning function, and other stakeholders relevant to the provision of secure services were satisfactory in responding to and predicting concerns about the quality of care.

5. Whether the Trust's current systems, processes and controls would give rise to the identification of similar issues now (and going forward) in all areas of care delivery.

Review approach

Review team

2.8 The review was led by Professor Oliver Shanley. Oliver is a mental health nurse by background and spent most of his career working in southern England. Oliver has held various Chief Nurse and Director of Nursing roles in provider organisations. More latterly, before retiring from the NHS, he was also the Regional Chief Nurse for London at NHS England and a Chief Executive Officer of a mental health trust.

2.9 Professor Shanley appointed a team of experts to support him in his work:

- **Dr Sarah Markham** is a visiting researcher at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. Sarah is a patient reviewer for the Quality Network for Forensic Mental Health Services at the Royal College of Psychiatrists and has lived experience of using forensic services. She acts as a patient representative for NHS England, the Care Quality Commission and the Healthcare Quality Improvement Partnership. Originally a mathematician, Dr Markham was awarded a PhD in Pure Mathematics from the University of Durham in 2003 after achieving undergraduate and postgraduate degrees from the University of Cambridge.

- **Dr Helen Smith** is a consultant forensic psychiatrist at an NHS trust where she was also formerly the Executive Medical Director. She is the former National Clinical Advisor in mental health to NHS England's Safety directorate team.

- **Jonathan Warren** is a mental health nurse by background and spent most of his career working in London. He is an experienced NHS executive and leader. Jonathan retired from the NHS in 2021, having been the Chief Nurse and Deputy Chief Executive Officer at a mental health trust for ten years, and latterly as Interim Chief Executive Officer of another mental health trust. Jonathan was formerly a National Professional Advisor for mental health nursing for the CQC.

2.10   The review team were also supported by two associates:

- **Priscilla Nzounhenda** is a mental health nurse manager who currently works in a forensic mental health service. She also chairs her Trust's Black and Minority Ethnic Network.

- **Dr Jeremy Kenney-Herbert** is a consultant forensic psychiatrist. He is the former Clinical Programme Director for a provider collaborative and Vice Chair of the Faculty of Forensic Psychiatry at the Royal College of Psychiatrists.

2.11   Support, investigative and governance expertise was provided to the review team by Niche Health and Social Care Consulting[6]. Niche is an employee-owned trust and a B-Corp[7] which specialises in providing independent patient safety reviews and investigations in the NHS. The Niche team consisted of:

- **Kate Jury**, Managing Partner - Kate is a healthcare governance expert and has worked with over 350 organisations in support of all aspects of governance; she also continues to write national guidance on the topic. Kate is also the Managing Partner of Niche and has led on several high-profile investigations and reviews.

- **Danni Sweeney**, Director - Danni is a Director at Niche where she specialises in NHS corporate and clinical governance. She is a certified Executive Coach and works with NHS organisations to improve their culture.

- **Sarah Dunnett**, Senior Investigator - Sarah joined Niche from the CQC where she worked for over 14 years in a number of roles, most recently in a senior role in acute sector regulation in the Midlands. Sarah maintains her NMC registration as a dual Registered Nurse in Mental Health and Adult nursing.

- **Gosia Davies,** Deputy Business Manager - Gosia is an experienced project manager. She joined Niche after eight years of running and overseeing a range of projects with complex partnership arrangements for a global insurer.

Review guiding principles

2.12   This review was complex, touched many different services and agencies and, understandably, provoked emotional responses in many people we spoke with. In designing our approach, we wanted to ensure that our work was guided by a set of principles (see 2.145) which would be reflective of the latest guidance and thinking around quality and safety, and that our work built on previous independent reviews in the NHS. These principles were guided by the following statements:

"Place the quality of patient care, especially patient safety, above all other aims".

"Engage, empower, and hear patients and carers at all times".

"Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work".

"Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge".

2.13   These statements start the executive summary in the Berwick Report (2013), '*A promise to learn, a commitment to act: improving the safety of patients in England'*, which was written in response to the Mid-Staffordshire tragedy. This report highlights, among other things that:

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[6] https://www.nicheconsult.co.uk/

[7] Certified B Corporations are businesses that meet the highest standards of verified social and environmental performance, public transparency, and legal accountability to balance profit and purpose.

a. In the vast majority of patient safety incidents, NHS staff are not to blame; it is systems, procedures, conditions, environment and constraints that they face that lead to patient safety problems.

b. Fear is toxic to both safety and improvement.

2.14 The NHS England Patient Safety Strategy (NHS England and Improvement, 2019) embraces these principles and recognises that while some progress has been made there is still much to do to improve the safety of services. This strategy focuses not only on creating safer systems for care, but also on doing this within a just culture. In short, we have not yet conquered fear within our healthcare systems and blame is a natural and easy response to mistakes and violations in care.

2.15 The work of Sidney Dekker sets out some key steps needed to make this shift. This work highlighted:

1. **Don't ask who is responsible, ask what is responsible.** Human factors show that people's actions and assessments make sense once we understand critical features of the world in which they work. There are well-known cases in NHS history (and indeed recently, in the case of Countess of Chester Hospital) of individuals who have deliberately set out to cause harm to patients. These are incomprehensible and rightly cause the public anxiety. They represent, however, a minute proportion of the overall care delivered by the NHS and should not set the overall context of how we review poor care.

2. **Understand the difference between work as imagined and work as takes place**. People are too often judged by those who do not understand the work that they do. They do not know the messy detail, they lack technical knowledge, and misunderstand the subtleties of what it is like working in a health system.

3. **People do not come to work to do a bad job.** It is important to understand the importance of restorative vs retributive justice; retributive justice focuses on error and violation of individuals. It suggests that if error or violation has hurt someone then the response should hurt as well. This can provide some comfort to those who have been harmed, as well as to their loved ones. Restorative justice, on the other hand, suggests that if error and violations cause hurt then the response should heal. Restorative justice fosters a dialogue between the individuals and communities involved, rather than a break in relationships through sanction and punishment.

4. **People are not the problem to control but the solution to harness**. Backward accountability means blaming people for past events, 'holding people to account' for what has already happened. This approach doesn't change what has happened and only achieves a sense of anxiety in others. This does not work to improve safety, and what actually happens is that people are motivated to be more careful about reporting and disclosure. Forward accountability changes the question being asked to "*what should be done about the problem, and who should be accountable for implementing those changes and assessing whether they are working in future*?"

5. **Supporting second victims and reducing the negative consequences and creating personal and organisational resilience.** Second victims are those who have been involved in error or violations where people have been harmed. Strong social and organisational support systems have proven critical to contain the negative consequences of safety incidents. The opportunity to recount the experiences first hand can be healing, if taken seriously and not linked to retribution. The lived experience of second victims represents a treasure trove of data about how safety is made and broken at the very heart of an organisation.

2.16 Some of the actions we saw staff take in BBC Panorama were dehumanising, degrading and may be found to be criminal in some cases. It is for the criminal justice system to make a judgement on criminality and for GMMH to decide whether their actions breached their contracts of employment and warrant further action. Our report seeks to understand how the conditions were created in which this behaviour could happen and could go unchecked and unnoticed.

2.17 We used a tool called the System Engineering Initiative for Patient Safety (SEIPS) to help develop an understanding of this. SEIPS provides a structure that supports an understanding of the different

systems within healthcare, their interactions with each other, and with the people who work within them.

Figure 1: Overview of the SEIPS framework
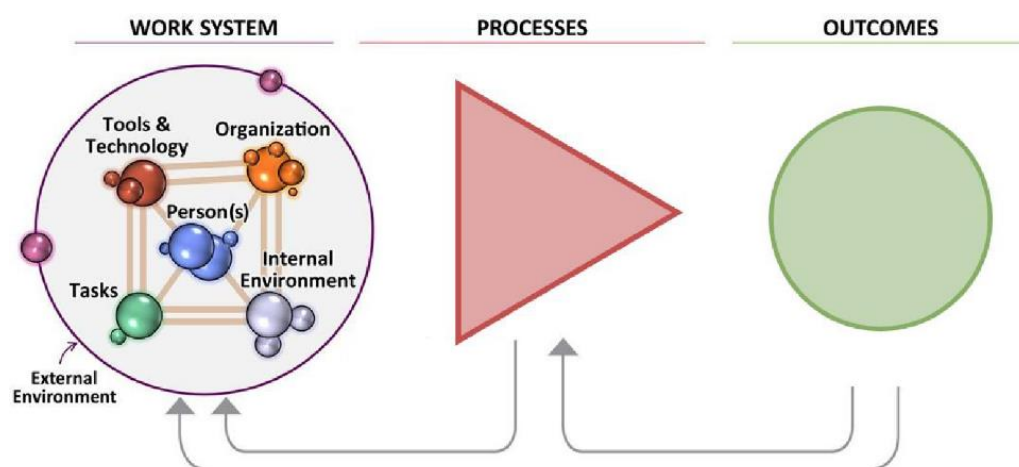
2.18   This framework helped us to identify and explore the interactions between all the various parts of the healthcare system in Edenfield and GMMH more widely. It consistently reminded us how complex this system is and steered us away from drawing simplistic 'cause and effect' conclusions. Most importantly, it reminded us that, other than in exceptional circumstances, people cannot be separated from their work system. Deliberate placement of 'persons' at the centre of the model above reminds us that healthcare systems should support (not replace or compensate for) people.

Method

2.19   Most of our work took place between February and September 2023. During this time, we met over 400 people to listen to their experiences of the Trust. The overwhelming majority of people approached to speak to us did so willingly. People were incredibly generous with their time, and for many this meant recalling distressing events at some personal cost. Those who did so underlined that they were sharing their stories so that the Trust could improve and so that patients would have better experiences in the future. We would like to sincerely thank all the people who met with us and shared their stories with such openness and candour.

2.20   Our approach to delivering the terms of reference described above has comprised:

1. Speaking to over 50 patients, families, and carers through interviews, focus groups and our visits to services.

2. Speaking to around 200 Trust staff, either in one-to-one interviews, during our visits to services, or in focus group environments.

3. Undertaking a series of visits to both Edenfield and other Trust services to see the care environment in its reality.

4. A focus group with members of the Council of Governors.

5. Reviewing a wide range of documentation from the Trust, including strategies, policies, meeting minutes and emails.

6. Reviewing documentation from the Trust's partners, including regulators and oversight bodies. This included documents and reports from the CQC.

7. Undertaking a series of interviews with around 50 of the Trust's stakeholders, including those from NHS England, the CQC and patient groups.

8. Analysing key data from the Trust. This included staffing and activity data and some financial information.

9. Undertaking a case note audit of 20 sets of patient notes from the Edenfield Centre (described in more detail at Appendix 3).

10. 'Sampling' other areas of the Trust where we identified early signs of concern, to understand the potential scale of issues, compared to what we found at Edenfield. Findings from this exercise are set out in Chapter 10.

11. Finally, we set up an independent email address where staff and other stakeholders from the Trust could contact us anonymously to tell us about their relevant experiences. This email address was shared with all Trust staff on three separate occasions.

2.21   Our work used Edenfield as its starting point by seeking to understand how the conditions for what was shown on BBC Panorama were able to develop. Using intelligence from the methods described above, we went on to explore three other services to understand any immediate quality or safety concerns. These were:

- Junction 17 and the Gardener Unit, which provide CAMHS in acute and medium secure settings, respectively;

- Woodlands Hospital, which provides care for older people with mental health needs; and

- Park House, which provides a number of services including acute care for adults of working age, wards for older people with mental health needs, and a rehabilitation ward.

2.22   This report tells the story of how the events of Edenfield came to occur and, in doing so, reflects the experience of many people, including patients, families and carers, staff, stakeholders and system partners.

Chapter 3 Context

This chapter of the report seeks to describe the environment which GMMH is operating in, both nationally and locally.

Mental health services in England

3.1   The goals for how mental health care should be provided in England were set out in the NHS Long Term Plan (NHS, 2019). Following COVID-19, the government published a recovery plan (HM Government, 2021) on how it was going to support the NHS to recover and deliver on the commitments made in the Long Term Plan.

3.2   Despite the increased funding provided through the COVID-19 Mental Health and Wellbeing Recovery Action Plan, mental health services remain under considerable pressure. Nationally, current vacancy rates stand at 9.9% for registered nurses (excluding vacancies filled by temporary workers) (NHS, 2023), and there is a shortage of medical staff working in mental health (NHS Digital data). We explore this further in Chapter 7.

3.3   In 2022, Parliament passed the Health and Care Act (legislation.gov.uk, 2022), which aimed to make it easier for services to work together to provide joined-up care for patients. This formalised the work of integrated care systems (ICSs). These are partnerships, consisting of NHS services, social care, and other organisations, which together provide care in defined geographical areas. Each ICS has an integrated care board (ICB), which determines what care is needed and how funding will be allocated to the various bodies in the ICS, including mental health trusts. One of the effects of this Act is that oversight of services now sits at a much higher level than under the previous clinical commissioning groups (CCGs). For example, in Greater Manchester, the ten CCGs have been replaced by one ICS. These represent significant shifts to how commissioners worked under previous arrangements, and we will come on to describe the impact of commissioning changes on GMMH in this report.

3.4   Alongside the national policy direction, there has been a heightened recognition of the need to improve mental health inpatient services. This has included important developments regarding restrictive practice, with greater requirements placed on mental health trusts through the implementation of the Mental Health Units (Use of Force) Act 2018. This sets out the oversight and management of the appropriate use of force in mental health and learning disability wards.

3.5   Other recent developments include:

- the publication of Rapid review into data on mental health inpatient settings: final report and recommendations (Dept of Health and Social Care, 2023);

- the publication of Acute inpatient mental health care for adults and older adults – Guidance to support the commissioning and delivery of timely access to high-quality therapeutic inpatient care, close to home and in the least restrictive setting possible (NHS England, 2023 a); and

- the launch by NHS England of the Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme (NHS England, 2023).

These reports set out how inpatient services must look to improve the overall experiences for people who require inpatient services. Importantly, they call for mental health providers to place a greater emphasis on listening to the voices of people with a lived experience and underline the role that the Trust Board has in the oversight of the quality of care.

The COVID-19 pandemic

3.6   The impact of the COVID-19 pandemic on the nation's mental health is still being realised and the full impact may remain to be seen for some time, particularly on children and young people. It is clear that a great many staff suffered high levels of distress as a result of their continued working throughout the pandemic. Supporting patients within mental health inpatient services and trying to keep them safe from the virus was enormously stressful for all staff.

3.7   GMMH experienced similar considerable challenges as the result of the pandemic, and, as an example, Woodlands Hospital (which cares for older people with mental health needs) had several patients who sadly died as a result of the pandemic. For staff across the NHS, there has been no time to 'recover' from what they experienced during the pandemic, and this has further added to the sense of stress and burnout for many. (Pollitt and Pow, 2022).

3.8   In its monitoring of the Mental Health Act (MHA), (legislation.gov.uk,1983) the CQC sought to understand the impact of COVID-19 on mental health care provision. Its report, Monitoring the Mental Health Act in 2021 to 2022, confirmed that workforce issues and staffing shortages remained the greatest challenge for the sector. Issues highlighted include the following:

- understaffing that affects the safety of patients and staff, with a lack of therapeutic treatment leading to an increased risk of violence and aggression on wards;

- chronic staffing shortages leading to challenges around the ability of staff to respond to incidents;

- untrained staff being asked to take on responsibilities they may not be able to carry out safely, and the impact of this on staff wellbeing;

- staffing shortages leading to a lack of patient involvement in decisions about care, reduction in ward activities, and patients' leave[8] being cancelled;

- increased risk of closed cultures developing;

- an adverse impact on therapeutic relationships if temporary staff are used frequently; and

- a 32% rise in 2021/22 in the number of under 18 year olds admitted to adult psychiatric wards because of lack of beds in CAMHS.

3.9   The report also underlines long-standing inequalities in mental health care provision, with:

- black or black British people over four times more likely than white people to be detained under the MHA, more likely to have repeated admissions and more likely to be subject to police holding powers under the MHA; and

- people living in the most deprived areas more than 3.5 times more likely to be detained than those in the least deprived areas.

About GMMH

3.10   GMMH provides mental health care services for people living in Manchester, Salford, Bolton, Trafford and Wigan. It also provides mental health and addiction services across Greater Manchester and more widely, as well as mental health care for patients in prison settings. The Trust employs around 6,400 members of staff across 109 locations. It has an annual income of £522 million.

3.11   In January 2017, the Trust (which had previously been known as Greater Manchester West Mental Health NHS Foundation Trust, or 'GMW') acquired Manchester Mental Health and Social Care NHS Trust, and GMMH was formed. This meant that the Trust became significantly bigger in a short period of time. The Trust grew further in April 2021, when it took on Wigan mental health services,

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[8] Patients who are detained under the MHA have rights to leave their ward or hospital for short periods of time, under certain conditions.

and a small number of Bolton and Greater Manchester-wide services. These had previously been managed by an organisation called North West Boroughs Healthcare NHS Foundation Trust.

3.12　At this point, the Trust changed its management structure, from 11 'divisions' to four 'care groups':

- Specialist Services Care Group (which included Adult Forensic Services and Edenfield)

- Wigan Addictions and Bolton Care Group

- Salford, Trafford and Therapies Care Group

- Manchester and Rehabilitation Care Group

3.13　More recently, following the screening of BBC Panorama, a fifth care group was created – Adult Forensic Services – so that these services would have additional oversight and resources.

3.14　The CQC is the main regulator of health services in England. Until October 2022, the Trust had been rated 'Good' overall by the CQC and was understood to be a high-performing organisation by many partners and oversight bodies.

About secure services

3.15　Forensic adult psychiatric services provide assessment and treatment for people aged 18 and over with mental disorders. These disorders include mental illness, personality disorders and neurodevelopmental disorders, including learning disabilities and autism. People often have more than one disorder.

3.16　People are liable to be detained under either part II or part III of the MHA 1983, civil sections or sections initiated through the criminal justice system and a significant number will have Home Office restrictions as part of their detention orders. People generally have complex mental health disorders which are linked to offending or seriously harmful behaviours. Assessment and treatment should be provided by a skilled multidisciplinary team of mental healthcare professionals.

3.17　Three levels of security exist across the forensic psychiatric hospital system: high, medium, and low security. Each provides a range of physical, procedural, and relational security measures to ensure effective treatment and care while providing for the safety of the patient and others, including other patients, staff, and the general public. Edenfield provides one of the larger forensic services in England. It has medium and low secure services for men, a blended medium and low secure service and an enhanced medium secure service for women. Edenfield has nine wards open currently within its medium secure building. Six wards for male patients: Dovedale (16 beds), Rydal (16 beds), Ferndale (17 beds), Silverdale (16 beds), Keswick (13 beds) and Newlands (6 beds). Three wards for females: Borrowdale (12 beds) and Derwent (6 beds) that provide a blended medium and low secure service, and Buttermere (5 beds) that provides an enhanced women's medium secure service. There are two low secure male wards: Delaney (15 beds) and Isherwood (15 beds) which are part of the Lowry Centre.

3.18　In the immediate aftermath of the BBC Panorama programme, five medium secure wards were closed. Originally there were a total of 18 wards across all services with a total of 164 beds; currently there are 13 wards open with a total of 102 beds. There are 92 male beds open and 24 female beds within this service. The unit is currently under-occupied, having closed to admissions after the Panorama programme in September 2022. There is also a community-based service called the Forensic Advice and Support Team (FAST).

3.19　Wards have changed their function over this time period and the current ward provision of care looks different to that provided pre-Panorama. This accommodates closed wards and wards moving as they are refurbished.

3.20　People accessing this service range between the ages of 18 to 70 years old, the majority being between the ages of 21 and 40. The ethnicity of the majority in all services is white; however, in the female services, nearly 17% are from black and minority ethnic groups and a further 7% identify as mixed heritage. Within the male services, 27% of those using medium secure services identify as

from a black minority group and 7% identify with mixed heritage; and in the male low secure group, 17% are from a black minority group and 3% from a mixed heritage (see Appendix 4). It is not uncommon for forensic services to have an over-representation of people from a black minority ethnic group.

3.21 There are a variety of pathways into secure care. Some people access the services via the criminal justice system, arriving in secure services as prisoners on remand or post-sentencing and a few from police custody. Others will enter services as a step up in current security from an open or low secure environment, or a step down from a high secure or medium secure environment. There will be some transfers from another hospital with the same level of security. Services work closely with partner agencies to share information at key stages of an individual's journey through secure services, to ensure that safety is maintained for the public and that individual. These include the law courts, tribunals, parole boards, the Home Office, multi-agency public protection arrangements (MAPPA) and His Majesty's Prison and Probation services. (Appendix 4 gives more information about the people using Edenfield's service.)

3.22 The nature of people's presentations using these services is such that every service needs to carefully consider how it uses restrictive practices (defined at 3.22). The use of these practices must be balanced with an individual's human rights. Consideration must always be given to providing care with the least restrictive practice and this should be kept under continuous review. The Mental Health Act Code of Practice 2015 states that "*any restrictive practice (e.g., restraint, seclusion and segregation) must be undertaken only in a manner that is compliant with human rights.*"

3.23 For the purposes of this report, we are particularly concerned with the following types of restrictive practice [9]:

- Physical restraint is any direct physical contact where the intention of the person intervening is to prevent, restrict or subdue movement of the body, or part of the body of another person.

- Seclusion is the supervised containment and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others.

- Rapid tranquillisation is the use of medication by the parenteral[10] route (usually intramuscularly or exceptionally, intravenously) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

3.24 It is important to note that any of these practices are harmful to patients and should only be used as a last resort. All efforts should be made to work with patients to manage their distress and de-escalate behaviours that may result in a restrictive practice at an early stage.

Greater Manchester health and care system

3.25 GMMH is part of the Greater Manchester ICS, although partnership working pre-dated the 2022 Health and Care Act. The region was seen as a trailblazer for partnership working, and in 2014, a Devolution Agreement (HM Treasury, 2014) was signed with Government, providing the region with additional powers and accountability through an elected mayor. Six devolution deals were agreed between 2014 and 2017, including the bringing together of health and social care budgets, with an associated £450m of additional funding in 2015.

3.26 Various changes followed to the way health and social care services were set up in the city, with NHS England overseeing transitional arrangements. Changes included:

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[9] Operational definitions: National Reducing Restrictive Practice Safety Improvement Programme

[10] Parenteral route means any non-oral means of administration.

- The formation of the Northern Care Alliance Group in 2016 (composed of Salford Royal NHS Foundation Trust and the Pennine Acute Hospitals NHS Trust). The Northern Care Alliance merged formally in October 2021.

- The establishment of Manchester University NHS Foundation Trust (MFT) in 2017, following the merger of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust. These two acute hospital trusts are now among the largest in the country and hold significant activity and budgets.

- The establishment of the Manchester Local Care Organisation in 2018. This is a partnership organisation, which provides all community care across the city of Manchester, and includes GMMH, Manchester City Council, the acute trusts and other bodies.

- The changes to how GMMH services have been configured are outlined at 3.111 above.

3.27 In short, there have been significant and consistent strategic changes to how health and care have been delivered in Greater Manchester in recent years. These changes, which were closely followed by the COVID-19 pandemic, have meant that the system (like many others) has been operating in a state of change for some time.

Finance

3.28 This review has not included a detailed financial analysis, although we have sought to understand, at a high level, any particular financial risks the Trust is carrying, which may have impacted or be impacting on patient care.

3.29 Data from the Royal College of Psychiatrists shows that spend on mental health services is lower in Greater Manchester than in other parts of the country. This data is not available at a Trust level.

Figure 2: Spend on mental health services per capita (adjusted for mental health need) across England and Greater Manchester
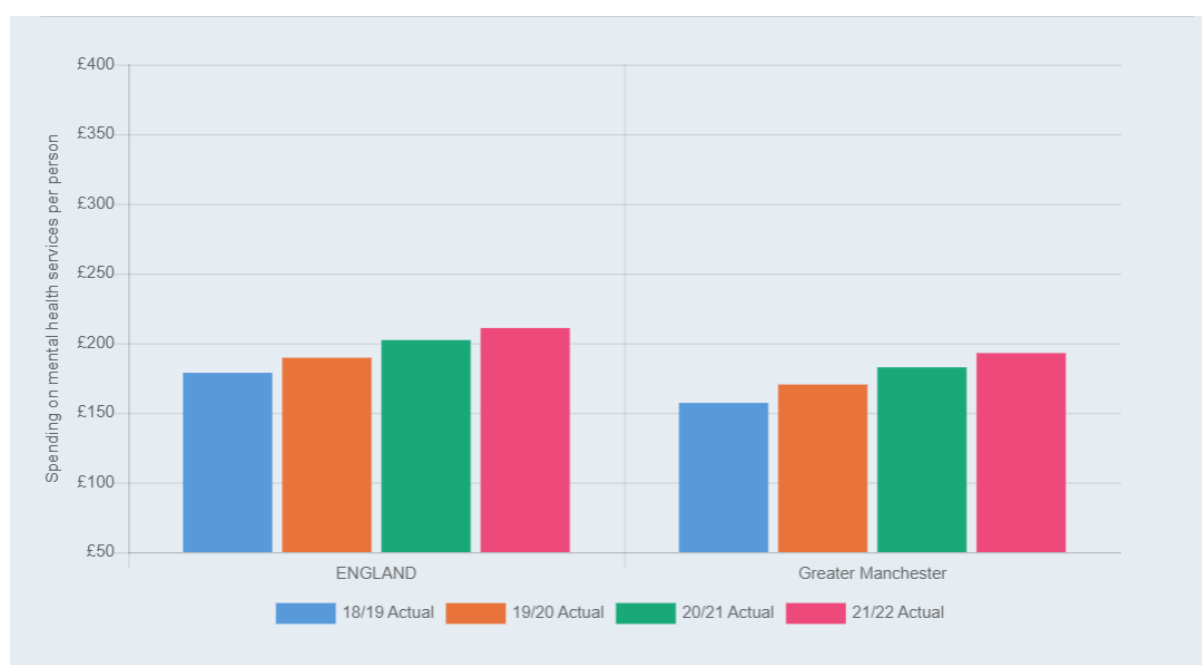
Source: Royal College of Psychiatrists

3.30 The chart above shows that mental health funding per person in Greater Manchester (adjusted for mental health need) is significantly lower than the national average and has been since this data began to be collected in 2018/19.

Figure 3: Proportion of commissioning spend on mental health services by area
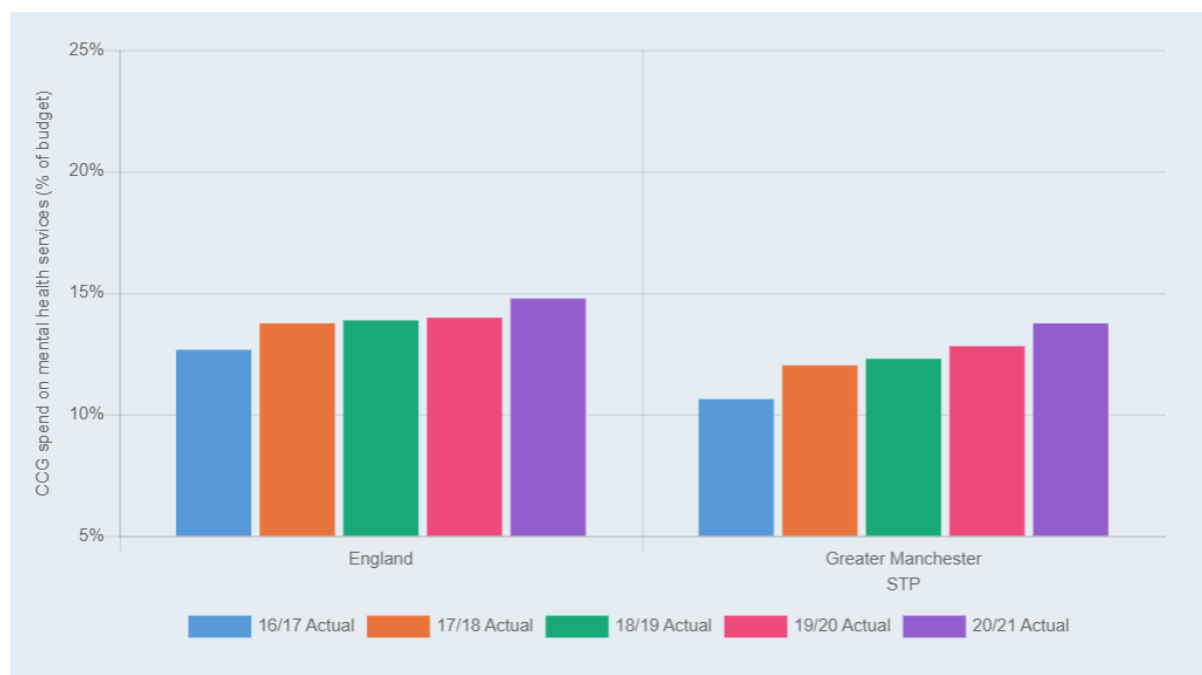
Source: Royal College of Psychiatrists
Note: STPs are what are now known as ICSs

3.31 In Greater Manchester, the proportion of healthcare spend on mental health services is lower than the national average, although this gap has narrowed in recent years.

3.32 At GMMH level, the Trust appears to be experiencing increasing financial challenges. Although meeting its break-even target in 2021/22, margins have been significantly eroded over the last six years, which leaves less scope for investment in inpatient care. Most of the Trust's income is via a "block contract" (88% in 2021/22) which means that it receives a set amount of money, for certain services it provides, regardless of how busy these services are. This kind of contract typically carries risk for providers, as funding is effectively capped regardless of activity, unless there are additional measures in place to mitigate this.

3.33 Income increased significantly (by approximately 70%) with the formation of GMMH (following the integration of GMW and Manchester Mental Health and Social Care Trust (MMHSCT) from 1 January 2017). The acquisition of Wigan-based services from April 2021 brought additional income to the Trust of approximately £35m in 2021/22 (almost 9% of total patient care income in 2021/22). However, the associated operating costs for the enlarged organisation have increased disproportionately to income. We also found less than inflationary increases in funding from Salford CCG, and that local authority income remained static over the period.

3.34 Staff costs represent most of the operating expenditure; they have increased in absolute terms and reflect the acquisition of services. However, as a proportion of total expenditure, staff costs have reduced by 5% over the period since 2015/16.

3.35 Overall, the Trust is managing its resources but in an extremely challenged financial environment, which in the context of significant quality concerns, will require focused leadership and support from both within the Trust and its partner agencies.

3.36 More widely, the ICB is also facing serious financial and performance-related challenges, and recently commissioned an independent review of the current leadership and governance arrangements at the Trust to identify any areas of improvement as there has been a deterioration in its financial position in the past few years. Efficiency measures are required to break even in 2023/24. The ICB reported a deficit of £125m after the first four months of 2023/24, which has been

reported as more than £100m worse than planned. The ICB has been placed in the 'mandated support' category of NHS England's regulatory regime.

3.37   This chapter has described the environment in which the Trust provides its services. In the following chapter, we recount what we have heard about the experiences of patients, families and carers who use these services.

Chapter 4 The voice of patients, families, and carers

> "*I tried to discuss the risks and concerns with them … but the Trust seem like they are firefighting and walking from room to room with fire, and petrol already in the room, smoking a cigarette.*"
>
> Patient's close family member

Introduction

4.1　In undertaking our review, we wanted to ensure that our starting point was trying to understand the experiences of people who received services from GMMH, notably Edenfield, and those who support their loved one in receipt of care. Had we had more time to undertake our work, we know that we could have met more people. We are also aware that GMMH serves a huge population and we do not claim that our findings will be representative of all that is happening across the organisation. The people we could speak with, however, set out some of the lived experiences of people who have been involved with a range of services, and whose voices need to be recognised to ensure learning can take place from the range of distressing events that have occurred within GMMH.

4.2　We listened to their experiences and have tried to capture the themes that emerged. We recognised that many of their accounts were distressing, also how privileged we were to hear their, at times, very personal stories. We were told often of the absence of kindness and compassion from some of those who were responsible for caring. For some people, this included very concerning descriptions of harm and abuse. Their accounts were compelling, often tragic, and were frequently a portrayal of a lack of consistent organisational oversight of quality over a sustained period of time.

4.3　We recognise that, while many of the people we spoke to had concerns, we were also struck by the level of understanding and regard they showed to some of the staff at GMMH in trying to deliver care in sometimes very difficult circumstances. Several spoke positively about those staff who had responsibility for developing patient and carer involvement, either in Trust-wide roles, or service-specific staff, such as those in Edenfield.

4.4　We repeatedly heard about the importance of co-production and the need for inclusion of people with a lived experience of mental illness, their families and loved ones. People wanted and want to be seen and treated as equal in the planning and delivery of care.

Why hearing and responding to the voice of patients and their loved ones is important

4.5　Patient-centred care has been defined as the provision of care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. It has become the focus of policy documents and mission statements, including the NHS Long Term Plan. The Recovery Model is predominant in mental health service policy, as is the recognition of the importance of person-centred practice and the positive impact it can have on outcomes for patients. Recovery-oriented mental health policy and practice aim to enhance the agency of the individual, prioritising self-determination, strengths-based practice and collaborative working. The NHS Long Term Plan commits to making personalised care 'business as usual' for 2.5 million people. (Markham 2020).

4.6　Inherent within patient-centred care are the principles of co-production. NHS England states that good co-production looks like this:

- Starting from what matters most to people who use and work in services.

- Working with people who have relevant lived experience (patients, unpaid carers and people in paid lived experience roles) and with staff.

- Building equal and reciprocal partnerships with people who have relevant lived experience and staff, including with those from disadvantaged and minority communities.

4.7   Drawing upon these policy positions we have asked ourselves how this aligns to what people have shared with us.

The GMMH approach to patient engagement and co-production

4.8   GMMH developed a service user engagement strategy (GMMH Together Strategy, 2022) that was published in 2022 and builds upon previous strategies. The new strategy sets out how the Trust aims to work in collaboration with "everyone" including the wider community. GMMH stated that the strategy was developed following extensive engagement with all relevant stakeholders and is, in its view, in line with all relevant national policies.

4.9   The strategy sets out four key ambitions:

1. **Meet your needs together** – Working with service users, their family and carers, and the wider community to deliver seamless care, promote choice and empowerment.

2. **Learn together** – Learning from lived experience and professional experience to support and maintain good mental health and recovery from addictions.

3. **Listen to your views and develop services together** – Listening to our service users, their family and carers, and the wider community, to improve service provision and access.

4. **Work together** – Co-producing and co-delivering services with people with lived experience and the Voluntary, Community, Social Enterprise (VCSE) sector to better meet people's needs.

4.10   There are several very positive areas within the strategy, that, if achieved, will undoubtedly improve listening to and learning from people with a lived experience. This could build upon some of the previous successes GMMH has achieved in developing services that are genuinely built around meeting the needs of the people it serves. This is an essential part of the Trust's improvement plan and has to be treated as high priority.

4.11   Recognising the expressed intent of the strategy and the hard work of the relevant organisational leads, we heard several accounts questioning the Trust's genuine commitment to engagement and co-production. We heard from GMMH staff who said that some managers were not committed to this agenda, and this made their work difficult to make meaningful changes.

4.12   We heard from patients, families, and partner organisations that the Trust needed to show more commitment to valuing the contribution of people with a lived experience. As a small but symbolic example, we were told about a patient story being prepared for the board of directors. This was to be the first patient story presented to the public board in several years, which required extensive support for the patient involved. At late notice the patient story was deferred and this, sadly, reinforced the perception that the Trust was not committed to hearing the authentic voice of service users. The Chair offered to meet with the patient's mother to hear the story personally and to be able to learn and respond; this meeting has now taken place. Subsequently, a patient story has been presented to the Board in July and September 2023, but the previous decision to defer would appear to have caused further concern to both patients and staff.

Raising concerns and complaints

4.13   An important element of co-production is the ability to respond to concerns raised. It became clear through a variety of sources that, until recently, the Trust had provided insufficient resource to adequately address complaints and concerns raised. The GMMH staff we spoke to were clearly working hard to meet the needs of the complainants but were challenged by a lack of resource and poor process. Staff told us that the Trust had grown significantly in recent years which had led to more complaints and concerns being received, but resource had not grown to match this.

4.14 A report was written by the NHS England North West Regional Nursing Team to GMMH that raises several concerns in this area including the following:

"*There was a lack of clarity and accountability throughout all the complaints process including an overly complicated tiering system.*

The information provided to the Trust Board was not sufficient to ensure effective scrutiny by Trust Board members; however, there should have been greater challenge by the Board regarding the lack of robust data.

There was a lack of clarity regarding 'Ward to Board' reporting. The Board appears to receive performance data in the form of run charts, but we did not see that themes, trends, learning, or actions undertaken by the Trust were shared in relation to complaints received.

There was limited evidence of a consistent approach to sharing learning and/or action planning; therefore, there is a clear risk of the Trust not being able to prevent reoccurrence."

4.15 However, it was recognised by the North West Regional Nursing Team that "*good practice was evident in some areas and most responses reviewed were of good quality and contained an apology*". Several recommendations have been made by the Improvement Team to enhance the governance and oversight of the complaints process. For example, it is highly unusual that the Trust has not had a Patient Advice and Liaison Service (PALS). It will be essential that the Trust acts upon these recommendations to improve insight and learning from complaints.

4.16 When listening to the experiences of people who complained, associated with other GMMH services, we heard various concerns including:

"*Not feeling listened to or valued, a sense that raising a concern was inconvenient to busy staff or that the professional voice was more important than the complainant.*"

4.17 Other examples of what we heard include:

"*Silencing dissent and not listening to criticism or properly dealing with complaints – blaming illness or the person making the complaint becomes the problem.*"

"*They talk down to you and it falls on deaf ears, try to talk you out of complaining, managers would say that they (the patient) are playing us off against each other.*"

4.18 We also heard numerous accounts where busy services did not always pay sufficient attention to the needs of patients, families and carers and these concerns were not fully addressed. Their accounts included the following:

"*Patients being discharged home in the middle of the night without any conversation with family. We were told the ward could not cope so they had to send [patient] home.*"

"*Said it wasn't just me that it affected it was him as well. He saw the unit firsthand because he was there every day bar one. For those five and a half weeks, he saw exactly what was going on. And he had to leave me there. He said that was the hardest thing. He couldn't say anything because he didn't know what they'd do. So if he said anything, he just wanted me home.*" (Charm[11]).

"*A family being asked to attend the emergency department following a serious self-harm incident and then being left unaccompanied by GMMH staff.*"

"*But they still, when I was in hospital, put men in my bedroom at the end of my bed. Where I've requested many a time I don't want a man in my bedroom. And they said we haven't got the staff. We've got to. We haven't got the staff.*" (Charm).

"*I tried to discuss the risks and concerns with them … but the Trust seem like they are fire fighting and walking from room to room with fire, and petrol already in the room, smoking a cigarette.*"

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[11] Charm Storybank, https://charmmentalhealth.org/

4.19 While there is some clear signalling of intent to place a greater value on the needs and voice of the patient, the actual reality of care for the people we spoke to was starkly different. The recommendations identified by the Improvement Team are important next steps to strengthen the complaints process but should be undertaken with a consistent view that every concern raised should be listened to and valued.

Patient experience at Edenfield

4.20 We listened to patients describe their past and present experiences at Edenfield. Many of them were upset and distressed by the BBC Panorama documentary and were grateful to the staff who had watched it with them and supported them with this. Some patients, when sharing their experiences with us, echoed what had been observed on Panorama. However, a number of the male patients we spoke to reported that the documentary was not representative of their experience of care at the Edenfield Centre and that they felt the programme "exaggerated things". Other patients spoke about experiencing worse treatment during their time in secure care than that which was evidenced on Panorama. We were told that patients' expectations of the system and staff had diminished over time and that poor standards of care had become normalised. In essence, for some, we felt this meant they would not always recognise what good care should look like.

4.21 Patients from ethnic minorities we spoke to reported that, although they hadn't received any racial abuse from other patients, they sometimes perceived those patients from a white British background received preferential treatment in terms of having their needs met first. One example frequently cited was faster access to psychological therapies. In a meeting with staff from ethnic minorities, they described how patients who were other than white had fewer opportunities for recovery than their white peers, such as white patients having access to leave prioritised in times of low staffing.

4.22 Staff described how disruptive behaviours enacted by white patients were more likely to be attributed to their illness, whereas for patients from ethnic minorities, it was perceived as more likely to be dealt with in a punitive non-therapeutic manner. We were told that this was more likely to result in restraint, seclusion, and rapid tranquilisation. One example included a black staff member being verbally abused by a white patient, and the ward manager diminished the incident, saying that it was because of the patient's illness. In another example, a white patient attacked a black patient and the response team arrived and wanted to remove the black patient who was the victim of the attack.

4.23 Although patients praised certain day staff (including receptionists) for being caring and responsive, there was concern across wards regarding some bank and agency staff employed by the service, mostly on night shifts. Patients reported that some bank and agency night staff would spend their time on the ward playing with their mobile phones and often sleeping. They described how some temporary staff were not responsive to routine requests for support made by the patients and instead often told the patients not to bother them or ask someone else. Members of our review team also witnessed day staff being unresponsive and at times rude to patients requesting their support.

4.24 The patients we listened to at Edenfield told us about the lack of meaningful daily activities with which they could engage and how this was particularly bad at the weekend when there was nothing to do other than watch TV and listen to music. They also spoke about their escorted Section 17 leave being regularly cancelled and how this impacted negatively on their wellbeing and recovery.

4.25 Some patients we spoke to were very positive about the Recovery Academy[12], its staff and the resources and opportunities it provided, but reported that too often a lack of staff to take them to the Recovery Academy meant they were unable to use it and had to remain on the ward, where there was little to do. Patients also told us that only a minimum of the full range of Recovery Academy courses were being run. From a centre-wide audit of a sample of care plans it appears that there is limited patient-staff co-produced care planning, risk assessment and risk management plans. This is

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[12]The Recovery Academy provides educational courses and resources for patients, families and carers and staff.

very disappointing given the excellent course on risk assessment offered but regrettably currently not being run by the Recovery Academy.

Raising concerns, governance and oversight at Edenfield

4.26 Raising a complaint or concern is difficult for patients, and perhaps even more so in secure services. We undertook some analysis of key data which showed that in total, 144 complaints were received by Adult Forensic Services between April 2020 and March 2023. Of these, 53% of complaints (77) were not upheld, 23% (34) were partially upheld, 13% (19) were withdrawn, and 10% (14) were upheld. We also looked at safeguarding data submitted to the local authority. Based upon the information provided to us, and prior to September 2022, the referrals were negligible despite the data showing that violence or abuse to patients represented 12% of all incident data between April 2020 and March 2023. Furthermore, we reviewed the incident data which revealed 102 allegations of violence, aggression, abuse or harassment by staff on patients.

4.27 It is clear to us that the governance system in both the local services and Trust-wide was unable to triangulate this data. We heard the Trust safeguarding team had not seen any significant growth in its resourcing, despite the increased size of the Trust. This impeded their ability to provide robust oversight of services, compounded by differing approaches across local authority settings. They described to us how they would not be routinely alerted to referrals made to the local authority by local services, which is compounded by the poorly developed safeguarding component of the incident reporting system.

4.28 We found, for example, that the central safeguarding team did not have a clear or complete oversight of the number or nature of referrals being made by various services across the Trust, including Edenfield. This affected the Trust's ability to provide routine monitoring information to the governance structure in GMMH. We believe this meant that the ability of patients to raise concerns was impeded and the opportunity for additional external scrutiny through safeguarding was diminished. We understand that the ICB, the CQC and the provider collaborative have identified an opportunity to strengthen the safeguarding arrangements for patient care.

4.29 Advocacy services are also important to understanding patient experience, and these can often act as an early warning signal of poor care. The advocacy service in Edenfield is well resourced, with six whole-time equivalent staff and a manager who has been in post since 2001. Each advocate covers two wards, which should give ample resource to be able to support people to clearly express their wishes and to help patients stand up for their rights. We understand that, pre-Panorama, the advocacy service would supply a quarterly report to the service manager and the advocates themselves had regular meetings with ward managers. These reports continue and highlight areas for improvement.

4.30 The advocacy service had a number of very experienced advocates who made considerable effort to advocate on behalf of the service users; despite this, some patients reported that the service was unable to achieve the outcomes they desired.

4.31 Good advocacy services require senior clinicians and leaders to want to hear the patient experience, wishes and rights, and act accordingly. It appears that over time this relationship had been unable to effectively challenge and change the prevailing practice, either due to a tacit acceptance of the circumstances by the Trust or through a lack of willingness to hear the effect of the circumstances on patients. Our view is that there is potential to improve the role that advocacy can play in ensuring the voice of the patient is at the forefront of clinical and operational decision-making.

4.32 We have also looked at several complaints raised by families and carers following the BBC Panorama programme. To the credit of the new leadership team at Edenfield, they commissioned an external review of these complaints, some of which pertained to events prior to the Panorama programme. There was a wide range of serious concerns, including the overuse of seclusion and restraint, poor communication with families and carers, inadequate staffing impacting on patient care and the suboptimal environment. The Trust upheld or partially upheld several of the concerns and subsequently apologised for the quality of care that patients had received.

4.33 The aspect of families and carers raising historical concerns post-Panorama is an important point. We heard from staff, patients and families that making a complaint was discouraged. Families told us they felt they were not always listened to or able to communicate with either loved ones or key staff members, all adding to a sense they lacked a voice. This was evident in various ways and we heard examples such as:

"*Staff members complain that since the phone system was changed a few years ago it doesn't really work. Ringing reception and getting through to the ward isn't possible and the ward phone often goes unanswered. There is a patient phone but it often doesn't work. I have personally had the phone put down on me several times – intentionally – by rude staff. The overall impression when ringing Edenfield is anything but professional.*"

 "*We felt that trying to access in either person or phone was extremely difficult. We met with hostility, incivility, rudeness and uncertain if any messages were conveyed to XX .*"

"*Every time I deal with Edenfield, and certainly when I visit, I am always left with a distinctly negative feeling. The lack of communication and clarity is draining… The gaps in information and lapses in sharing pathways and action plans feels disorganised at best, and somewhat apathetic.*"

4.34 We also heard how many staff tried hard to be compassionate and caring and respond to concerns. We were told that:

"*I am generally very satisfied with the care XX is receiving – all the staff whom I have met appear to have a positive and caring attitude…. is being offered a wide range of therapeutic, developmental and recreational activities, and… is deriving much benefit from them. I particularly commend a member of staff named XX, who has been most caring and diligent in support.*"

4.35 A number of the people we spoke to expressed their concern for the staff working at Edenfield. They recognised that it could be a very stressful and challenging environment, often compounded by a lack of staff. They said that this, aligned to what they described as a lack of leadership oversight, could have played a significant part in some of the concerns they raised. We heard examples such as:

"*I think staff need more support for their distress including simple things like rest rooms.*"

"*We don't believe there are enough staff and this makes it so difficult for them and for us, that can't be right.*"

Summary

4.36 One of the most fundamental elements of supporting people who experience mental ill health, namely compassion and kindness, was often missing in the accounts from patients and their loved ones. We also heard that some patients, families and carers were not universally treated with dignity and respect. At times this went far further and for some this amounted to the most appalling abuse. We are mindful that a police investigation is continuing.

4.37 The Trust is attempting to build upon its work on co-production and ensuring the voice and experience of patients, families and carers are heard. This is most evident through the Trust service user engagement strategy. The Trust is also fortunate to have some excellent staff who are working hard to facilitate improvements in listening and responding to the patient voice. Based on the multiple accounts we heard, however, there remains significant room for improvement.

4.38 All of this will require senior leaders to demonstrate that they are genuinely committed to seeing patients, families and carers as equal partners in every aspect of the organisation.

4.39 Moving on from the experience of those receiving care, we will now discuss how the Trust was led.

Chapter 5 Leadership

Overview

5.1   Leadership is crucial in the successful running of any organisation. There is a significant focus on leadership in the NHS because the style of leadership adopted sets the tone for how staff interact with each other. This in turn determines the kind of culture an organisation will have, and in healthcare, evidence shows that culture has a significant impact on the quality of care provided.

Board of directors

5.2   This section considers the impact of the Board on the leadership of the organisation. We discuss its impact on the governance of the Trust in Chapter 8. As regards leadership, the role of the board of directors in an NHS trust is to set and lead a positive culture in the organisation. (NHS Providers, 2015). Since the BBC's exposé, the composition of the Board has changed substantially, and the CEO and Chair have both stepped down. A number of interim executive directors are in post.

5.3   There is an expectation in NHS trusts that the Board acts as a unitary body. This means that:

"*Within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility and liability. All directors, executive and non-executive, have responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.*" (NHS England, 2022).

5.4   This did not always happen at GMMH. In reality, many non-executive directors told us they felt that at times challenge had been unwelcome at the Board, and that reasonable questioning could be interpreted as unfair and disproportionate. This, in our view, led to the effectiveness of non-executive directors being reduced over time, to the extent that some executives and senior leaders in the organisation told us that they did not feel held to account by the non-executives. This may be due to the lack of credence given to the non-executive directors by the executives. Our observations of the Board and its subcommittees confirmed a need for greater levels of appropriate challenge, to ensure that information presented is being scrutinised properly. This lack of cohesion is mirrored in other forums and teams throughout the Trust and is looked at in detail at Chapter 8.

5.5   The ability of the Board to challenge management effectively was also hampered by its lack of visibility in the organisation which is likely to have limited its understanding of the nature and breadth of the services provided by the organisation. A significant feature of our conversations with staff was that most were completely unfamiliar with the Board. This has meant that staff lacked faith that the Board really understood their services or their experiences. Furthermore, Board members had a reduced ability to corroborate what they read in formal papers with what they see and feel 'on the ground' in services. Non-executive directors told us, during interviews, that they had been surprised by the lack of expectation that they visit services to speak to staff and patients. We were told that visits had reduced following the pandemic and had taken a long time to return to their former frequency. This is important as it reduces the gap between the perceived reality of service delivery and the actual reality of care. We are aware that the new interim Chair and interim Chief Executive have been more visible; current practice includes a monthly Town Hall session for all staff to hear from and raise questions with them and a weekly note to staff is written by the interim Chief Executive.

5.6   Going forward, it is critical that Board members role model (to each other as well as the wider organisation) a culture of compassionate, inclusive and transformative leadership. Visibility is an important part of this, but it needs to have a purpose, which includes ensuring that Board members set the tone for how other leaders in the organisation should behave.

Executive team

5.7   The executive team of an NHS trust leads the day-to-day management of all aspects of the trust's business, including patient care services, operations, finance, and all the corporate support

functions which enable services to run. As the most senior management in the organisation, they (along with their Board colleagues) set the tone for all other leaders in a trust.

5.8   At the time of writing, the executive team of GMMH is in a state of transition and therefore there is not currently a stable leadership team. Notably:

- The Chief Executive Officer is in an interim position, with the previous role-holder having resigned and left the role on 30 June 2023. The present post-holder was recruited and contracted to stay until March 2024 to enable recruitment and safe handover to a substantive Chief Executive. The recruitment to the Chief Executive role is underway.

- The Chief Operating Officer is interim. We understand that recruitment to this position is ongoing.

- The Chief Nurse retired in August 2023, and there is an Interim Chief Nurse currently in post and recruitment to the substantive post is underway.

- The Medical Director left the organisation in late July 2023 and an interim covered the post. A new Medical Director joined the Trust in September 2023.

- The Acting Human Resources Director left the organisation in July 2023 and the substantive Executive Director of HR returned to the role at this time.

5.9   While there is some stability brought by executives in corporate support functions (including finance, performance and also the Deputy CEO), it is crucial that a substantive executive team is brought together as soon as possible to provide stability for the organisation during this difficult period, to reset the organisational culture, to support staff, and to deliver the improvements needed. The substantive new appointments need to bring the right blend of values, skills, capability and experience. While recruitment is ongoing, it is imperative that the existing leadership continue to drive the improvements needed.

5.10   We were consistently told that previous executive directors have not worked cohesively, collaboratively or effectively together in the past, and that this has had a significant and detrimental impact on team working and wider culture throughout the organisation. Clinical leadership in particular has had insufficient prominence in the Trust, and there is a widespread belief that the organisation has prioritised performance over a strong clinical voice. This is further explored in Chapter 6. Team cohesion will be crucial as new appointments are made as this will role model the expected dynamics for care group leaders and multi-professional teams throughout the Trust.

5.11   We also heard that the executive team was not visible in the organisation. We have seen written evidence from a member of staff in Edenfield raising concerns to members of the executive team about worrying working practices and behaviours in Edenfield. Their email expressly outlined the need for executives to visit the service and see these issues for themselves. They received no response for six months and the eventual response did not address all of the issues raised by this individual.

Senior leaders

5.12   As described in the introduction to this report, in 2022 the organisation moved to a care group management structure. Care groups are now managed by a multi-professional team consisting of an operational lead, a senior doctor, and a senior nurse. The latter was a late addition and had previously been described as a 'quality' role. This is reflective, in our view, of the historical lack of prominence given to nurse leadership throughout the Trust. The former 'divisions' did not have these senior and prominent clinical roles, and instead, all management responsibility sat with the Associate Director of Operations (ADO). The portfolio for these roles appears to have been unfeasibly large, and we support the move to the trio structure which should help to distribute workload, better utilise expertise (particularly relating to quality and safety), and better serve to champion clinical leadership in decision-making.

5.13   There has historically been a lack of ethnic diversity among the Trust's leadership. While this has recently improved somewhat, work remains to ensure that the Trust's leadership is more representative of the populations it serves. Additionally, we were told that there was a lack of diverse perspectives, leadership styles and external experience among operational managers and clinical leaders. Every staff group we spoke to described a culture of having to "*toe the line*" and adhere to expected norms and behaviours. Key comments in this area included:

- "*You'd be promoted if your* "*face fit*". *I knew mine did, and so I was ok, but I saw people who didn't fit the mould, and they'd be treated very differently.*"

- "*We did psychometric testing and most of us came out with the same personalities and styles.*"

- "*I* "*grew up*" *in GMMH; I just thought that's how leaders behaved.*"

5.14   Staff throughout the organisation consistently described to us worrying behaviours from several senior leaders in the organisation. Some of these concerns had been reported to the Freedom to Speak Up Guardian (FTSUG)[13]. Examples of poor behaviour described to us included: shouting, swearing, telling staff to retract incident reports and to withdraw written staffing concerns, over-riding clinicians' decisions made based on patient safety, and fostering an attitude of intimidation.

5.15   Several of these people have been subject to or are currently undergoing independent HR investigations. Many of them remain in very senior positions in the organisation. It is critical that the Trust assures itself that those in senior leadership positions now are exhibiting and role modelling the values and behaviours the Trust requires, in order to reset and reshape its culture to one which can provide safe services.

5.16   During our interviews, a small number of these senior leaders reflected on their own management styles following the Panorama broadcast. Some of those we spoke to have since received developmental support to adapt their leadership style. Some key comments in this area include:

- "*Looking back over time, I can see now that some of my behaviours weren't right.*"

- "*I thought that's just how management acted. I didn't know any different.*"

- Someone also described to us how leadership behaviours coming from Edenfield had a "*mushroom cloud-like*" effect on the organisation, as many of the Trust's senior leaders came from Forensic services.

5.17   Others, however, displayed a lack of reflection and awareness of the effect that their behaviours had had on staff, and the potential impact of this on the care they delivered to patients. These people were more likely to blame clinicians for not reporting more incidents, or for not delivering care in line with clinical standards. These attitudes left us with the impression that much more personal reflection was needed.

5.18   Equally important is that the Trust realises the benefits of having a multi-professional team leading each care group. We were consistently told that the Trust had disproportionately prioritised operational performance, to the detriment of clinical quality. We were told that the opinions of doctors, nurses and other professionals simply had not been heard or valued in the organisation. There is a clear opportunity now to reset this through the care group leadership structure, together with learning from what went wrong at Edenfield. It is crucial that the Trust seizes this opportunity to make the changes now needed.

5.19   We understand that a care group development programme was commenced but has since stalled. Senior leaders we spoke to hoped that this would be reinstated so that they have protected time to reflect on (and start to embed) different ways of working to support a change in culture. We would expect, given the organisation's challenges with its staff engagement and culture, that any programme of this nature would have a significant focus on compassionate and inclusive

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leadership, and making the Trust's values real. This does not appear to have featured in the care group leaders' appointment processes, development or job descriptions to date.

Leadership within Edenfield

5.20   As in the Trust more widely, we heard that the model of ward leadership and multi-professional working was not always cohesive and sufficiently focused on the quality of care. We repeatedly heard that the 'operational voice' was too dominant and paid insufficient attention to those in clinical roles. We believe there is a need for much closer, multi-professional working between the consultant and ward manager, which is supplemented by specialist input from other members of the nursing team, psychologists and therapists. A more coherent and stronger clinical voice is essential in ensuring that the leadership focus is based on quality and meeting the needs of patients.

5.21   Clinical leadership at Edenfield has been disjointed, with a number of medical leadership roles within this service. We understand that this was a deliberate strategy to attempt to strengthen medical leadership, given the Trust's practice of allowing insufficient time for clinical leadership roles. In practice, this did not work, and we found an unclear medical leadership model, confusion around roles and a perceived lack of openness and transparency around appointments to some of the leadership roles described. When combined with the primacy and dominance of the operational voice described above, it is not difficult to see how the service lost its clinical conscience in decision-making over time.

5.22   Clinicians we spoke to gave us various examples of their being closed out of important decision-making, or else over-ridden by operational management. For example:

- managers closing a ward without increasing the beds or staffing on other wards, or ensuring adequate physical space to meet patients' needs; and

- a manager giving an e-cigarette to a patient with a known associated risk of arson, without reference to the clinical team.

5.23   Doctors told us about long-standing issues about the reporting of nurse staffing numbers to the Board and Specialised Commissioning, with doctors concerned that the numbers being reported did not fit with their everyday experience of the ward environment. Every member of consultant staff in the inpatient service told us that they raised concerns about the number of nursing staff on their wards.

5.24   When raised with management, these concerns were not listened to, or were dismissed or minimised. We also heard that management told doctors that the MHOST[14] was being used and that some areas were overstaffed and over-establishment[15]. The manager is reported to have said "*s**t rolls down hills*" which was interpreted as meaning that they feared reprisals from those more senior than them in the organisation if they pushed this matter. One consultant described being told that they needed to "*stop siding with the nursing staff*". The national nursing shortage was often quoted as the reason for any perceived understaffing, with no possible solution in this context.

5.25   Additionally, there was a lack of visible leadership on the wards, all of which supported the development of a closed culture. We were frequently told that key leaders, including consultants, senior nurses and ward managers were typically based in their offices or, as a possible legacy of COVID-19 working, virtually from home, ostensibly doing administrative tasks. The impact of this was threefold:

1. Many managers and clinical leaders were disconnected from the everyday challenges of direct care staff. This made it easier for them to minimise or dismiss concerns raised.

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[14] MHOST is a tool developed to support Mental Health Trusts to measure patient acuity and dependency levels in order to inform evidence-based decision making on resourcing/establishment setting, alongside professional judgement.

[15] Staff establishment means the posts which have been created for the normal and regular requirements of the organisation: over-establishment is when more staff are permanently employed than the number which has been agreed as necessary.

2. There were missed opportunities for managers and clinical leaders to consistently role model expectations, and to offer on-hand guidance and support. This is particularly the case for temporary and new staff, and preceptees (recently qualified nurses), who would have required closer supervision and direction to develop the skills needed to care well for Edenfield patients.

3. There were missed opportunities for those in more senior roles to challenge practice which fell below expected standards. This was clear in the Panorama documentary, in which healthcare assistants featured can be heard saying "*we wouldn't get away with this with the managers here*".

5.26 Leaders set the tone of an organisation and have a significant impact on its culture. The following chapter considers in detail the culture of GMMH and Edenfield.

Chapter 6 Culture

Introduction

6.1 Organisational culture describes the shared ways of thinking, feeling and behaving in an organisation (Mannion and Davies, 2018). Safety culture in NHS organisations has been a key and recurring theme in reports where there has been poor care for example in the Francis Report (Francis, 2015), Morecambe Bay (Kirkup, 2015) and the Ockenden Report (Ockenden, 2022). The dominant features of the culture of GMMH, and more specifically Edenfield, will be described in this chapter, in which we also pay particular attention to the safety culture.

6.2 Culture is everywhere, making it difficult to understand precisely what it is and how best to assess it. If we see organisational culture as a dynamic social construct and consider the culture of an organisation to develop through interactions between individuals within teams and between different teams, this helps improve understanding. Organisations have typically focused on more process-driven measures, to consider how individuals or teams work together, rather than the quality of work people do together. It is often only when outcomes are poor or relationships break down that organisations try to understand how teams are working together, as a reactive response.

6.3 Trust boards have a responsibility to set and lead a healthy culture (see 8.3). The importance of compassionate leadership in supporting the delivery of high-quality care and innovation in healthcare and the role that leaders play in establishing this culture is well recognised. (West et al, 2017):" What *leaders focus on, talk about, pay attention to, reward and seek to influence, tells those in the organisation what the leadership values and therefore what they, as organisation members, should value.*"

6.4 The role that a compassionate and inclusive culture plays in staff health and wellbeing and retention is further underlined in NHS People Plan (NHS England, 2020).

The Trust

6.5 For NHS boards and executive teams to function well and in a unitary capacity, the voices and perspectives of all members must be heard and respected. Equally, individual and collective roles should be understood and valued. This principle is echoed in the GMMH strapline: "*Clinically-led, operationally partnered, academically informed*". Throughout our work, however, the opposite was described to us, with a predominantly operational voice and weak clinical leadership. We heard how the culture of the Trust was one that was more interested in organisational growth, maintaining a positive external reputation and achieving performance targets.

6.6 We were told that this manifested in the Board and the executive team enabling operational services to have too great an influence across the Trust. We also heard that the Board and the executive team paid insufficient attention to the importance of quality across the Trust, and that the value, ability and effectiveness of clinical leaders was minimised. This was shared with us on multiple occasions and seen as a key element of the culture that the Board and executive team set across the Trust.

6.7 The annual National Staff Survey (NSS) gives every Board a window on the culture of the organisation and allows comparisons to be made with peer organisations regionally and nationally. This allows NHS trusts to consider how they are functioning and formulate plans to improve any areas of concern.

6.8 GMMH NSS results for 2022 are among the lowest for all mental health trusts in England across many measures. We analysed the 2021 results too, to act as a control for what might be perceived as a 'Panorama effect' (i.e., if the broadcast had affected morale and engagement Trust-wide). While there was a slight deterioration from the previous year, 2021 results were also generally very low. Throughout this chapter, and in Appendix 2, we have highlighted some of the most notable results.

6.9 The Trust has also sought to understand its culture through the commissioning of an Organisational Behaviour Audit delivered by an external company, in 2019. It was piloted in the Specialist Services Care Group, which contains Forensic Services, among others, in response to concerns raised via Freedom to Speak Up (FTSU). The audit was completed by 273 of 813 staff, which is a response rate of 34%.

6.10 This report signals concerns in Forensic Services, which we explore further below. We have seen little evidence of how the findings of this review have been progressed across either specialist services or the Trust. This has been fed back to the Trust in other recent external reviews. Of note, the report states that:

- "*Key findings across specialist services also included 'unacceptable' levels of stress, work overload, a sense of disempowerment and pockets of unsupportive management.*

- *"… Content analysis of the qualitative data (comments) highlighted a number of themes and it can be seen that perceptions of poor management, difficulty to speak out, understaffing and work overload/stress occur most frequently, across the five departments. Thematic analysis by work unit identified that most comments were made by the Forensic Mental Health unit, where the above issues were most commonly cited. More specifically, issues of understaffing, poor management, difficulty to speak out and work overload/stress seemed to trouble most respondents. That being said, there were some respondents who did not identify their work unit. Thus, caution should be taken when interpreting the results.*"

6.11 These themes continue to feature in the Trust's 2022 NSS results:

Figure 4: National Staff Survey – People Promise (PP) 3: We each have a voice that counts
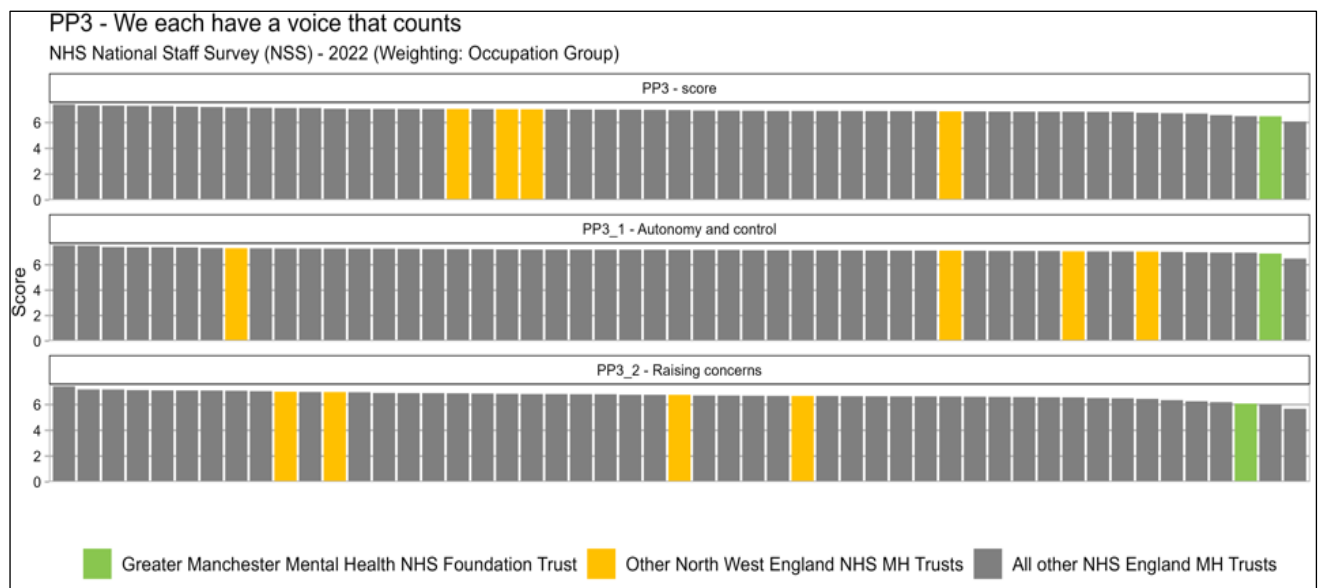
6.12 This is the second lowest score out of all English mental health trusts and is a decrease of 0.3 from 2021.

6.13 Clinical leadership has been undervalued in the organisation historically. An example of this is poor management of leadership supporting professional activities (SPA) afforded to medical leaders to undertake their roles (too diffusely distributed or inadequate), and in the fact that nurse leadership roles have only very recently been introduced into the care group leadership model.

6.14 Instead, there was a strong view at all levels that operational performance and finance were the organisation's key priorities. It is important, from our perspective, to highlight that strong performance had served the organisation well historically. In many ways the organisation was viewed positively in the Greater Manchester health and care system, and it had been rated Good by the CQC. This culture, however, led to and was shaped by various behaviours which may have impacted on quality of care, including:

- A strong drive from the Trust's leadership to maintain their positive reputation with partners. An example in this area was a pressure from the Trust's leadership to admit patients from local emergency departments, even if people in the community were in greater clinical need of an inpatient bed.

- Various cases of operational managers over-riding clinical decisions made, particularly in relation to reducing the number of staff needed to support a patient in various clinical situations. We heard that one manager reduced observation levels so that fewer staff were needed, contrary to clinical decisions made.

- Clinicians not being invited to (and indeed, feeling explicitly unwelcome at) key meetings. Where clinicians were invited, such as to the Commissioning Committee, not all disciplines were included (no doctor was invited) and the clinician who was invited did not always attend.

- An overall sense that all staff should paint the Trust in a positive light when dealing with regulatory and oversight bodies, including NHS England, commissioners and the CQC. Staff felt that this was "*just the way things were done*" and that they couldn't be fully transparent in these interactions about the pressures their services were facing.

- A lack of diversity in leadership styles, with a perception that some staff were promoted to senior roles based on the extent to which their management behaviours reflected the dominant norms. This was a leadership style which was at times aggressive and lacked compassion and patient-focus in its approach.

- Staff recruitment processes were frequently described as lacking openness and transparency, and lack of equality experienced by minority ethnic staff all contribute to deficiencies in the inclusive behaviours that support the safest cultures.

Positive safety culture and speaking up

6.15 There are well-recognised factors which engender a positive safety culture, which include, among other things: inclusivity and civility, teamwork, and psychological safety. People who feel psychologically safe are confident about telling the truth and vulnerabilities are welcome in their workplace. They believe that they will not be punished or humiliated for speaking up about concerns or mistakes, or with questions or ideas. The extent to which staff feel able to raise concerns openly is a key determinant of how safe a healthcare culture is. Again, this can be measured through the NSS. GMMH's NSS results in this area are some of the poorest results nationally.

Figure 5: National Staff Survey – I would feel secure raising concerns about unsafe clinical practice
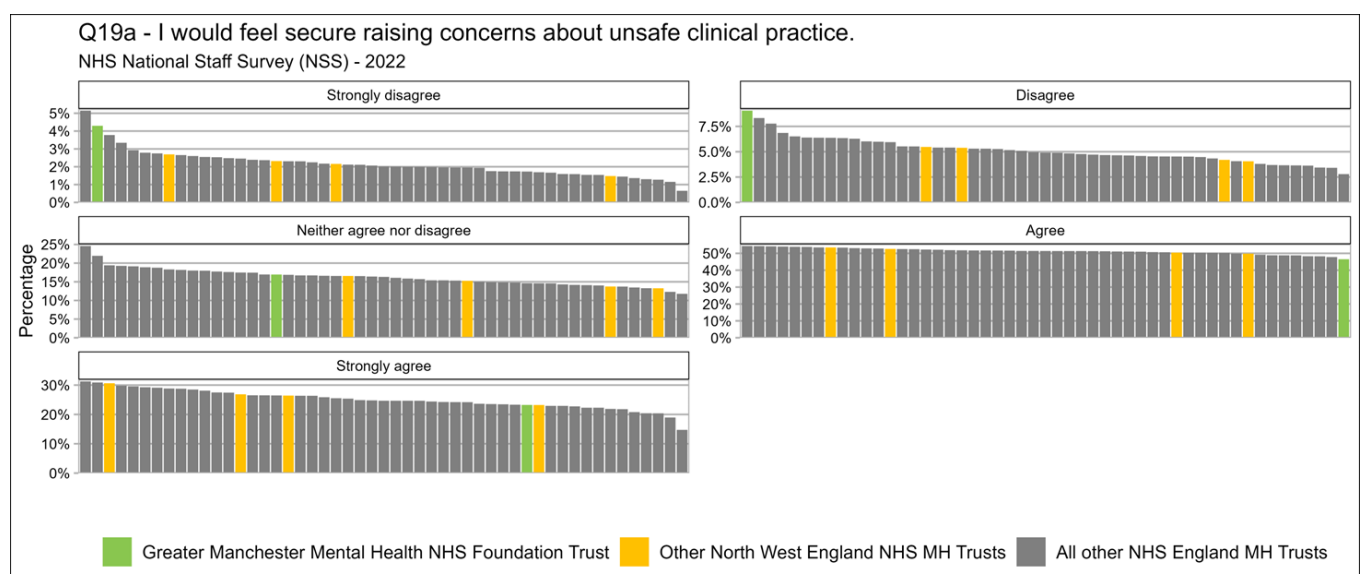
Q23b - My organisation acts on concerns raised by patients / service users.
NHS National Staff Survey (NSS) - 2022

Legend: Greater Manchester Mental Health NHS Foundation Trust | Other North West England NHS MH Trusts | All other NHS England MH Trusts
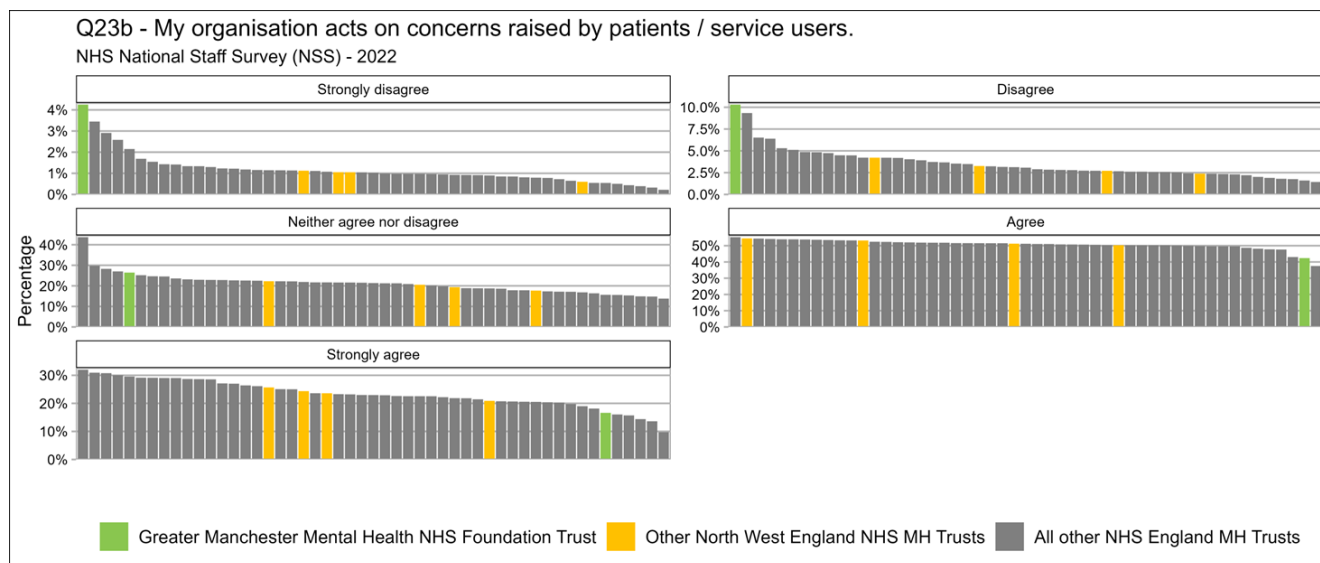
6.16   We heard, consistently and at every level of the organisation, that raising concerns was unwelcome. Many people we spoke to described incivility and belittling if they raised concerns. This is reflected in the number of cases raised via FTSU, which appears to have been low for an organisation the size of GMMH. Indeed, the Organisational Behaviour Audit described above at 6.9 was, in part, commissioned to understand if staff knew about FTSU.

6.17   We also note that many staff from Edenfield raised concerns directly to the CQC rather than via the organisation's internal routes. This could suggest a lack of faith in the internal structure. At the time of the broadcast, there was an Associate Director with responsibility for FTSU. This person was also the substantive Associate Director of HR, which we believe posed a conflict of interest with their full-time role. The Francis Report (Francis 2015) described the importance of the FTSUG as being independent and impartial, and this has been repeated in guidance since Francis from the National Guardian's Office (2022).

6.18   While the Trust has since recognised and remedied this, it is concerning that a need for impartiality and independence had not been safeguarded in this important function. There is now a full-time middle-management level (Band 8B) FTSUG in place, which is more reflective of good practice, as well as a Band 6 Deputy in the team. Various Board members meet with the Guardian to go through cases raised and seek to understand the information coming through.

6.19   Some senior staff said during interviews that the organisation interpreted low speak-up numbers as positive assurance, when in fact, this may have been a missed opportunity to explore why staff might not be using the service. We note at Edenfield, for example, that in spite of the scale of known cultural issues, no cases had been taken through FTSU in the last three years, although concerns were raised directly to the CQC from Forensic Services. The FTSU report Q3 2022 (following Panorama), states there was "*a 400% increase in contacts to the FTSUG*" (73 contacts in total) compared with the same quarter in 2021. The vast majority of these were linked to staffing and patient safety. This is suggestive of the broadcast and the new management team having given staff 'permission' and a voice to speak up about their concerns across the Trust.

6.20   That said, our review of FTSU reports to the People Culture and Development Committee and Board found that information they contained was limited in how useful it might be in understanding the Trust's culture. For example, rolling data for the number of cases raised is only provided in-year, and by quarter, so it is difficult to see how the volume of cases is rising or falling over a longer time period. There is little intelligence on the content of issues raised and where they come from in the organisation, nor how this is used alongside other workforce intelligence (such as turnover, grievances or NSS) to identify services potentially in distress. There is little information to tell the reader what has changed as a result of staff speaking up, or what the impact of the service is on the organisation's culture.

Discrimination

6.21 The Trust is aware that it has issues relating to how staff with protected characteristics, particularly race, are treated at work. This has been reported through the staff survey, the recent report at Park House and data collected through the Workforce Race Equality Standard (WRES). Our analysis of WRES data found that, in 2023:

- 19% of the Trust's staff are ethnically diverse, but only 9% of staff at middle manager grade and above (Band 8A+) are other than white, for clinical management roles. This number is even lower in non-clinical management roles, at 3%.

- Ethnically diverse staff are 13% more likely than white staff to experience harassment, bullying or abuse from colleagues.

- Ethnically diverse staff are 1.62 times more likely to enter into formal disciplinary processes, compared with white staff.

- White applicants are 0.83 times more likely to be appointed from shortlisting for jobs compared with ethnically diverse applicants.

- White staff are 1.66 times more likely to access non-mandatory training and professional development opportunities than ethnically diverse staff.

6.22 We were also told about experiences of staff from ethnic minorities at Edenfield who said that some colleagues would encourage patients to say racially abusive things to them. Staff described seeing staff from ethnic minorities being undermined by white colleagues.

6.23 Black staff told us that they had been told there was no point applying for promotions. When a black member of staff had decided to apply in the face of this advice, they were not told the outcome of an interview for several months, and only heard they had not got the job when they asked one of the interviewers directly.

6.24 Following particular concerns being raised about racism towards staff working at Park House, an internal review was commissioned, which reported to the Board in July 2023. Chapter 10 describes this work. The improvement plan that we reviewed (see Chapter 9) considered this issue specifically at Park House, with action plans focusing on this site specifically. However, the Trust has publicly acknowledged that the issue is Trust-wide and has established a Board committee to address equality, diversity and inclusion issues within the Trust. In the section below, we discuss what this was like for staff with protected characteristics, working in Edenfield.

The culture at Edenfield

Introduction to Forensic Services

6.25 To understand the culture at Edenfield, we must first describe what it is like to work in secure psychiatric services.

6.26 In Forensic Services, the environment that staff work in is unique to other mental health services, in that patients are invariably detained under the Mental Health Act, have very little or no say in their admission to services and are often admitted because they have exhibited behaviours that are a serious risk to themselves or to those around them. Many are admitted in the most tragic of circumstances. At their best, forensic care roles can be immensely rewarding, but at their worst, they can be damaging and destructive, with staff being fearful of coming to work, traumatised, demoralised, stressed and burned out.

6.27 At the very least, in the early parts of admission to services, many patients are distressed, do not want to be there and mistrust the system that is working to support them. Many of them have extensive histories of trauma and other adverse childhood experiences. People who use secure mental health services are the ones who pose the highest risk among those using the mental health system, but they are also some of the most vulnerable in our society.

6.28 Forensic psychiatric services provide care that supports these people to recover from their mental health problems, to manage their own mental health and safety, and to reintegrate back into their communities, reducing the risk of the behaviours that brought them into services from reoccurring in the future.

6.29 The potential for Edenfield to have developed a closed culture, by the very nature of the services it provides, is also material; services are physically locked with obvious physical security measures, patients are removed from their loved ones and communities (and other protective factors) and stay for months or years.

Shortness of staffing and impact on culture

6.30 In late 2018, a concern was raised with the FTSUG about staffing levels in the Specialist Services Network (now Specialist Services Care Group). This includes CAMHS, Forensic Services, Substance Misuse Services and Mental Health Deaf Services. The concerns were escalated to the CEO who commissioned an internal review, to be carried out by a senior leader in the Trust. This looked at 24 wards within the network. The Trust was unable to provide a final copy of the report and in this chapter, we are referring to the draft report which was shared with us.

6.31 The findings included that:

- across the network, there were conflicting systems for recording staffing levels, which led to confusion for managers;

- data did not clearly identify where the staffing shortfalls were. It was not unusual for wards to be left without registered nurses; and

- there was a ban on agency nurse use, there was a 15% shortfall of nurses and staff were not always reporting staffing issues.

6.32 With specific reference to Edenfield, the draft report states that: "*There is conflicting data and significant variation between what is being reported internally and externally in relation to planned and actual staffing levels. For example, Keswick Ward which appears to have the highest number of gaps in Registered Nurse cover does not appear to be reporting safe staffing exceptions at all. Managers who were interviewed said it is currently not unusual for shifts to operate without a Registered Nurse on duty, particularly within the Edenfield Centre.*" [16]

6.33 The draft report made four recommendations:

- *"Enable a transparent management culture where staff feel able to raise concerns.*

- *Simplify the system for planning, reporting and monitoring transparent and accountable staffing levels.*

- *Integrate the planning of shifts across the top and bottom Prestwich sites, with combined managerial oversight, a single Bronze on-call system, and an integrated duty management system.*

- *Lift the ban on using agency within the Edenfield Centre if all options have been systematically explored to meet minimum Registered Nurse cover."*

Our review of the action found mixed progress against agreed timescales.

Psychological safety at Edenfield

6.34 As described above, the ability for staff to learn from when things go wrong is linked to the concept of creating a just culture and psychological safety. This means creating an environment of fairness, transparency, and learning. It recognises that work is messy, mistakes happen, and people's actions

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[16] Where patients are detained under the MHA, there should always be a registered nurse on duty in the ward. If there is not, this should be reported and escalated as a matter of urgency.

make sense only when we understand critical features of the world in which they work. There was no culture of psychological safety or just culture at Edenfield.

6.35   We were told of various examples, occurring over many years, where staff were ignored, their concerns were minimised, they were reprimanded or experienced professional retaliation for speaking up about poor practice. Reporting of concerns (such as unsafe nurse staffing levels) was actively discouraged and was described by numerous people as being "career limiting". One such example described to us include:

- A former staff member described "*a very punitive management ethos which seems to have relentless fault finding, in whatever form, as one of its main priorities. My experience is that such fault finding is not related to efforts to improve standards of patient care but is used as a more general means to retaliate against and otherwise silence anyone who is prepared to question aspects of practice that they consider are of concern.*"

6.36   There became an almost unanimous lack of faith among staff in Edenfield that anything would change as a result of raising concerns via all available routes. A great many staff, of all professions and levels, were highly distressed when telling their stories. Many said that this review was the first time anyone had spoken to them about their experience of working at the Edenfield Centre and wider GMMH.

6.37   At a service level, this looked like low reporting for staffing and 'no harm' incidents. At the most senior levels of the organisation, this looked like pressure to present performance in an opaque, vague and unduly positive light to reduce the Board's capacity to interrogate information effectively. Key comments in this area included:

- "*We were constantly told that staffing was fine at Edenfield. Once we were even told that we were overstaffed. You just stop mentioning it eventually... It was just the way things were.*"

- "*You just couldn't raise anything. The response would have been, 'well that's your job, why haven't you handled it?'*"

- "*We just gave up in the end*".

Summary

6.38   The culture of an organisation is determined by its leaders who are, in an NHS trust, the Board. We have heard from Trust staff and seen through the lens of the National Staff Survey that there is significant room for improvement in the organisational culture of GMMH. Staff reported that they had not always felt safe raising concerns and that for many, their voice and opinions were not valued. They describe this as an organisation that facilitated operational services to be dominant and did not sufficiently value or regard the clinical voice or pay proper attention to the quality of some services.

6.39   This was further enabled by the Board not addressing the capacity and effectiveness of clinical leadership across the organisation. In the absence of direction from the Board and the executive team, we heard of fractures and divisions emerging, leading to a lack of cohesive leadership. We have been told during interviews that both the previous CEO and Chair had been told about concerns regarding the effectiveness of the working relationship between the Chief Operating Officer, the Chief Nurse and the Medical Director. We saw little evidence that this was effectively addressed. This dynamic was reflected in multi-professional relationships in various other parts of the organisation.

6.40   When examining the impact of culture on local services, notably Forensic Services, it cannot be looked at in isolation from leadership, staffing and governance, and indeed, other areas in the SEIPS model described in the introduction to this report. What is clear is that all of these facets had an interdependent and detrimental impact on each other, until the culture of Edenfield became toxic and harmful to the safety and wellbeing of the patients cared for there.

6.41   However, the issues described in this chapter must not be seen as specific only to Edenfield; they are reflective, in our opinion, of wider cultural challenges in the organisation. In its response to this report, it is imperative that the new Trust Board seek to understand this problem fully, alongside the complexity of these services. To do this will involve acknowledging the importance of leadership, staffing and governance in improving the overall culture of the organisation. These areas have been identified in the improvement plan which is discussed in Chapter 9.

6.42   This chapter has described the culture of the organisation and Edenfield specifically. In the following chapter we look at the importance of the workforce in delivering care.

Chapter 7 Workforce

National context

7.1 The influence of adequate staffing who know the patient is an important requirement for the maintenance of relational security, therapeutic alliances and successful outcomes for patients. (Royal College of Psychiatrists Centre for Quality Improvement, 3rd Edition 2023)[17]. Staff shortages are a long-standing challenge in the NHS. Data published by NHS Digital for mental health shows high vacancy rates across clinical nursing roles[18]. In the North West of England the vacancy rate is worse than nationally for medical vacancies, but better for nursing vacancies, as shown in the table below.

Figure 7: Vacancy rates in mental health: England overall and the North West

Role	England (mental health) total % vacancies (March 2023)	North West (mental health) total % vacancies (March 2023)
All roles	9.9	9.9
Nursing	18.1	15.9
Medical	14.0	17.5

7.2 The national context has placed considerable strain on services in mental health. Staff have had to adapt to working without sufficient numbers to try and keep services safe and maintain therapeutic alliances with patients. If services and trusts fail to recognise and plan for the impact of this short staffing, they are likely to struggle to maintain safety and quality.

Trust-wide nurse staffing

7.3 As stated above, the Trust is experiencing significant staffing pressures. Of note:

Vacancy rates – In June 2023 the Trust had a vacancy rate of 14.4%. The turnover rate was 15.4%, which is above the 12.5% Trust target. The most commonly stated reasons for leaving were promotion elsewhere (14 leavers), closely followed by work/life balance (13 leavers).

Agency use – Bank and agency staffing costs were 13.9% of the Trust pay costs in June.

Sickness – In June 2023, the sickness absence rate was above the Trust target, at 6.2% against a target of 5.6%; however, Forensic Services were a 'hotspot' at 9%. The top stated reasons for absence are mental health issues and musculoskeletal problems.

Safe staffing reporting

7.4 The Trust Board receives regular updates from the Chief Nurse on staffing levels. Since Panorama, the Trust has improved the quality of how it reports safer staffing, including that understaffed areas can now be more easily identified. However, further development is needed before the Board can be assured that there are sufficient nursing staff to deliver safe care. The report is now much more explicit in describing the Trust's staffing challenges, although it would be helpful if the quality and safety risks associated with this were also clearly articulated. During one observation of the Board, we also saw examples of understaffed wards reported, which was not questioned or probed by Board members.

7.5 For example, while the use of temporary staffing to backfill gaps in staffing is included and is on the improvement plan, this is not linked to the known risk that temporary nursing staff from NHS

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[17] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-forensic/forensic-see-think-act-qnfmhs/see-think-act---3rd-edition.pdf?sfvrsn=f8cf3c24_4

[18] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey

Professionals are not trained in the use of Prevention and Management of Violence and Aggression (PMVA),[19] or the ability of a temporary workforce to develop therapeutic alliances with patients. The Trust told us that they had started training temporary staff in October 2022. We requested the PMVA training records of NHS Professional staff and the Trust told us in July 2023 that there were no records of this.

7.6 The ability to support patients who may be expressing distress is a fundamental and critically important skill for nursing staff working in a forensic setting. A reduction in this capability within a ward team will impact upon the ability to intervene and diffuse such behaviour early to try and prevent the episode escalating and requiring a more restrictive intervention. The situation is further compounded if the patient requires restrictive interventions because staff not trained in PMVA are not able to restrain people safely.

7.7 Staff described incidents on the wards where an alarm was raised that necessitated staff to attend from other units to support containment of a violent situation that the ward staff could not manage. On wards already depleted of staff, and with high levels of temporary staff, the inability to get a response when help is needed results in risks to the safety of patients and staff. This, in turn, contributes to a working environment in which staff feel fearful. The evidence to support this and knock-on impacts for patients and staff are described in the following chapters of this report.

7.8 The Trust has made progress in reviewing nurse staffing levels and has recently completed the MHOST on inpatient wards. The next step is to undertake structured establishment reviews for all inpatient wards. The Trust plans to use the Telford professional judgement model which also considers professional judgement, nursing practice, leadership, finance, and estate. It is likely when this is completed that the vacancy rate will be higher than it currently is because the current vacancy rate is measured against an establishment number which has not been calculated using a recognised tool.

7.9 The Trust is required to report on Care Hours per Patient Day (CHPPD)[20]. As shown below, for all nursing staff, the Trust is mitigating registered nurse shortfall by filling gaps with non-registered staff. GMMH had the lowest CHPPD for registered nurses, compared with all other mental health trusts in England, with 2.3 hours across all inpatient wards, which was 1.2 hours less than the national average.

Figure 8: Care hours per patient day

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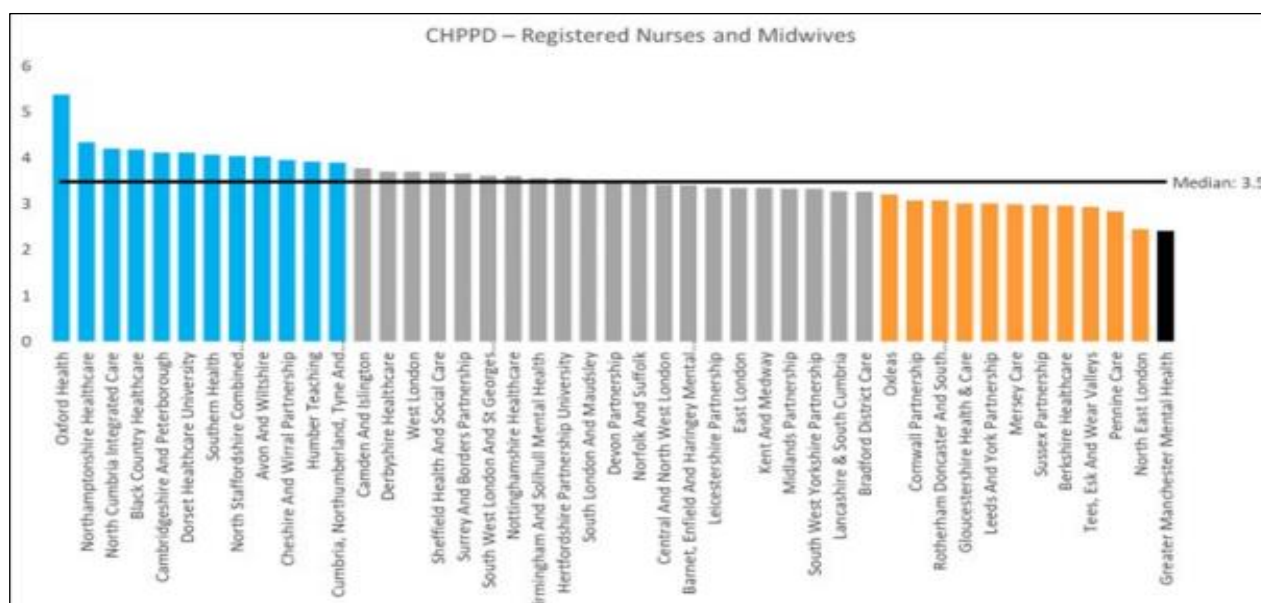
[19] Prevention and Management of Violence and Aggression, which is the Trust's approach to restraint reduction and reducing restrictive practice.

[20] This calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours available. CHPPD is calculated by taking actual hours worked, divided by the numbers of patients at midnight, split by all clinical wards' established workforce (qualified and unqualified).

7.10 It is good to see that the GMMH Safe Staffing Report to Board reflects the current position, although more can be done to triangulate the current staffing position with its impact on the quality of care for patients and the experience of direct care staff.

7.11 Until recently, Safe Staffing reports to the Board were vague, with an overly optimistic tone, and often contained information which did not reflect the reality on wards. As an example, a report from September 2021 stated:

"*Ward staffing establishments are locally set but are based on some common planning principles including the standard to have 2 registered nurses on duty*" (sec 3.4); and

"*No shifts left uncovered by Qualified staff and those with less than the planned were compensated by unregistered staff*" (sect 4.1*) …* "*With the exception of a few incidents all wards had at least one registered nurse on duty*" (sec 6.1).

7.12 This is not happening in practice, and it appears that staffing levels have historically been set from the available budget rather than from clinical need. A number of staff at Edenfield told us that there were many shifts without even a registered member of nursing staff planned to be on the rota (often on Keswick and Derwent wards), and that one qualified nurse would cover up to three wards. Our review of rotas and regulatory reports confirmed this.

7.13 The CQC inspection report, 2022 reviewed four weeks of rotas from Monday 23 May to 19 June 2022. Out of the 336 shifts on the female wards there were 72 shifts (21%) where there was no registered nurse on duty. These figures include Derwent and Keswick wards, where the establishment is set as no registered nurse on night shifts. It is telling that even having shut four wards post-Panorama, the unit was reporting to a minimum standard of one qualified nurse per shift. Between the week commencing 6 April 2023 and the week commencing 20 June 2023, there was a minimum of one registered nurse per shift 52.4% of the time, and two registered nurses 47.5% of the time. During this time period there were five occasions without a registered nurse. Since 25 September 2023, the Trust is now reporting to a minimum standard of two registered nurses per shift.

Staffing at Edenfield

7.14 Immediate actions taken after BBC Panorama meant that staffing improved following the closure of wards and redeployment of staff. Despite this positive improvement in workforce, staff described to us chronic concerns in regard to workforce which had been apparent for some considerable time. The new leadership team are working hard to address these matters but will require significant support given the size of the challenges.

7.15 The clinical model at Edenfield (as in every service) was designed based on the assumption that wards would be fully staffed by experienced, trained and supervised staff. In reality this is not happening. We were told by Edenfield managers that MHOST was used to review Edenfield staffing levels in 2019. We have not seen the outputs of this exercise but were told by management that it showed a clear staffing deficit on some wards (contrary to consultants' feedback on this, who said that management told them the service was overstaffed according to the tool). We have seen no evidence of actions taken as a result of this staffing review. The COVID-19 pandemic appears to have resulted in a loss of focus and attention on the staffing review. Since 2019, establishments and ward functions have changed, although the tool has only recently been used again by the NHS England support team.

7.16 In all our interviews with clinicians, staffing was the most commonly identified concern. Key issues raised included:

- Shifts planned with no qualified staff, which is contrary to any recognised standards for nursing practice.

- Qualified staff regularly holding keys for up to three medium secure wards both during the day and at night. In a review undertaken in 2019 following concerns raised, staff had reported holding keys for up to five wards. Ward keys include medicine keys so there may be a delay for

patients getting medicines if the nurse holding the keys is on another ward as they will have to do medicine rounds on more than one ward. They may not be able to respond quickly if a patient needs medicine outside of rounds.

- Newly qualified nurses (preceptees) working as the sole registered nurse on wards and some examples of preceptorship[21] nurses covering more than one ward. Preceptees should not be running wards until they have been signed off as competent. It remains regular practice that preceptee nurses are left as the sole registrant.

- Unregistered staff recounted to the review team regular examples of being left for periods as the only member of staff on the ward, working unsupervised and unsupported. Some told us that they had had to resort to locking themselves into offices to ensure their safety on occasion.

7.17   Consultants all told us that nursing levels were too low to manage the wards or the complexity of the patients and, at times, felt unsafe. There were descriptions of consultant staff having to relieve their nursing colleagues of keys and duties when nursing colleagues were not available to take over responsibilities at the end of shifts.

7.18   They said that patients reported that their observations were not being completed reliably, despite enhanced observations being in their care plans. In addition, staff moves were regular occurrences (sometimes two or three times a shift to maintain minimal staffing coverage) with staff describing not knowing which ward they would end up on when they arrived at work. Good relational security, which is critical to maintaining safety in Forensic Services, will be severely compromised by this practice.

7.19   Consultants described the impacts of these low staffing numbers and unstable staffing on care; nurses often did not know the patients on their wards well and they were unable to attend core clinical meetings about patients and share their input. This had a serious impact upon patient care with, on occasion, poor adherence to their care plans. As an example, a patient was able to fashion a ligature from clothing and choke on a piece of slipper while two nurses were providing continuous observations[22].

7.20   In addition to this lack of qualified staff, there have been high numbers of vacancies and high sickness rates.

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[21] Preceptorship is a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning." Health Education England (2017).

[22] Three levels of observation are available:
   • Level 1 observation: Continuous – within eyesight.
   • Level 1 observation: Continuous – within arm's length.
   • Level 2 observation: Intermittent.
   • Level 3 observation: General Observation. From the GMMH Observation policy 2018: issue date 4.1.2023 due for review 9.5.2023

Staff Group	Financial Year				
	2019/20	2020/21	2021/22	2022/23	Total
Additional Professional Scientific & Technical	1%	3%	8%	3%	**4%**
Additional Clinical Services	9%	9%	11%	14%	**11%**
Administrative and Clerical	7%	10%	9%	7%	**8%**
Allied Health Professionals	9%	7%	2%	10%	**7%**
Medical and Dental	1%	0%	0%	5%	**2%**
Nursing and Midwifery	6%	7%	9%	9%	**8%**
All Adult Forensic Service Staff	7%	8%	10%	11%	**9%**

7.21 Sickness rates are continuously high across staff groups. This has risen over time among allied health professionals in particular. It is extremely high among nursing staff.

Figure 10: Adult Forensic Services vacancies by staff group and financial year, April 2020 to March 2023

Staff Group	Financial Year				
	2019/20	2020/21	2021/22	2022/23	Total
Additional Professional Scientific & Technical	27%	35%	21%	18%	**26%**
Additional Clinical Services	12%	20%	26%	30%	**22%**
Administrative and Clerical	19%	44%	47%	12%	**30%**
Allied Health Professionals	7%	2%	19%	16%	**11%**
Medical and Dental	13%	13%	9%	8%	**11%**
Nursing and Midwifery	29%	25%	25%	26%	**26%**
All Adult Forensic Service Staff	18%	21%	25%	27%	**23%**

7.22 Nursing vacancies are consistently high over the period reviewed. Despite these factors, we were told that managers were reluctant to use agency nursing as they would not understand the service. The vacancy rate is against an establishment figure that has not been calculated using a recognised tool.

Shift patterns

7.23 Within this context, direct care staff at Edenfield often worked very long hours, with 13-hour shifts commonplace. Similar services in other trusts also have long shift patterns. However, at Edenfield, staff were working very long shifts like this, and:

- without a proper break;

- extending these hours even further due to a lack of staffing at the start of successive shifts;

- as the only qualified member of staff, and sometimes as a preceptee; and

- sometimes with responsibility for multiple wards due to staffing constraints.

Working in these conditions is testament to the commitment of many staff to the service and their patients, but the link between long hours and shift work and a deterioration in staff concentration, empathy and own wellbeing is well known (Caruso, 2014).

Figure 11: Lengths of shifts worked in Adult Forensic Services

Distribution of AFS lengths of shift
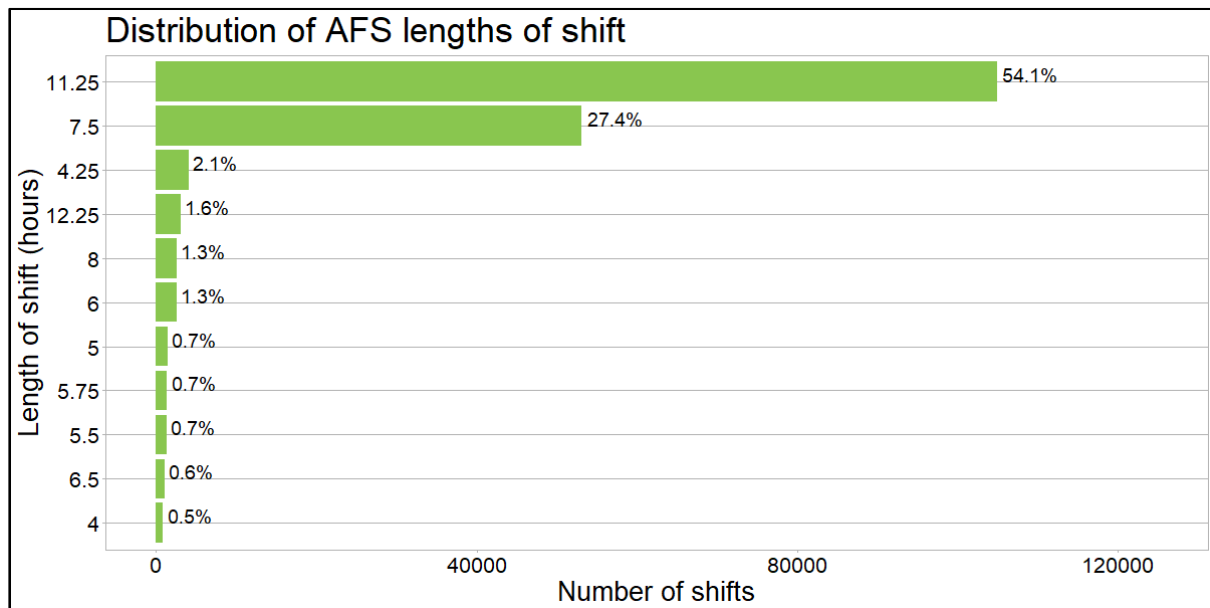
7.24   Our analysis in this area found that most shifts worked in Adult Forensic Services in the last three years have been over 11 hours.

Figure 12: Percentage of shifts worked where staff worked more than 48 hours per week in the previous 7 days

Percentage of shifts where staff members worked over 48 hours in the previous 7 days
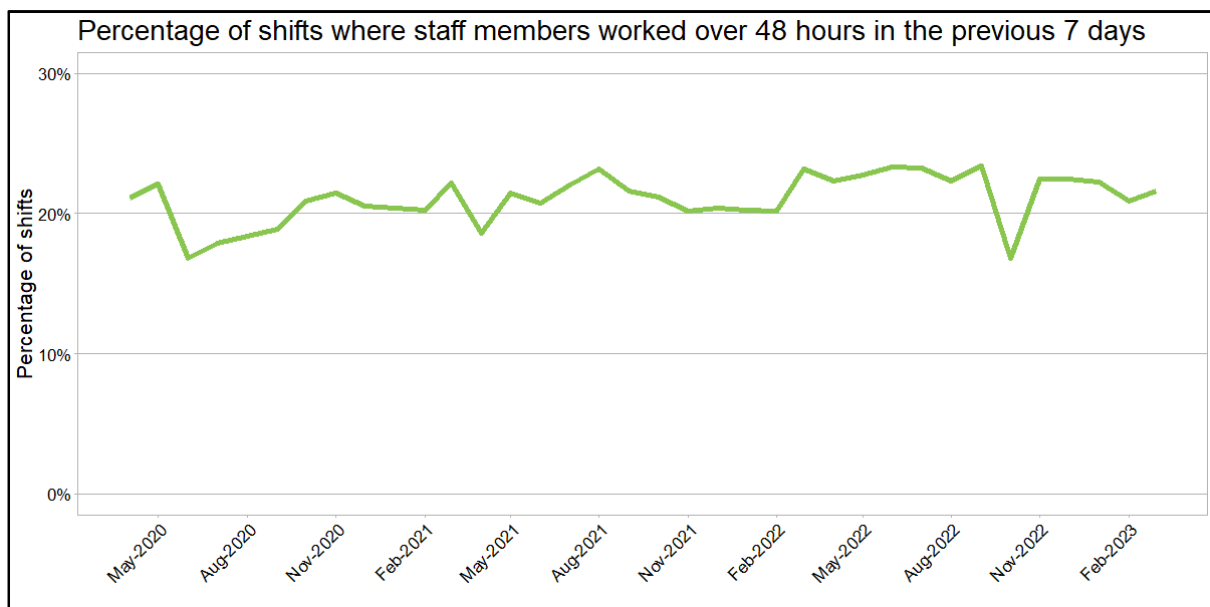
7.25   In addition, staff are regularly working over 48 hours per week at Edenfield (in the context described above at 7.23).

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Figure 13: Distribution of number of hours worked over the 7 days prior to shift ending

Distribution of number of hours worked over the 7 days prior to shift ending
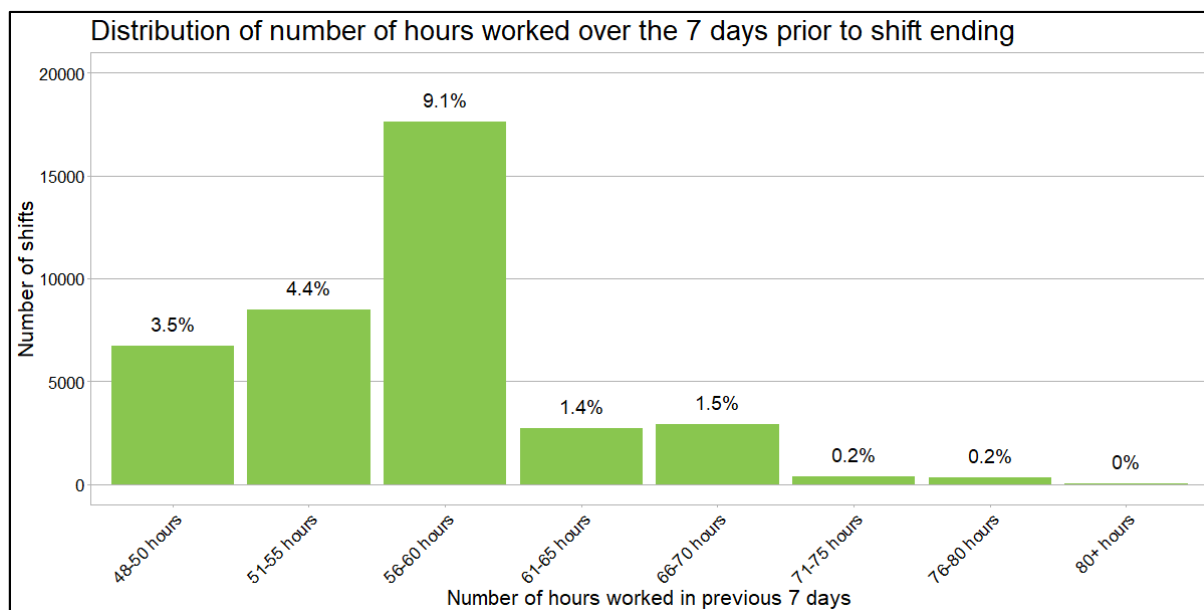
7.26 Over 12% of all shifts completed over the three-year period were for staff having worked over 55 hours in the previous seven days.

7.27 We recognise that some of this data may be influenced by the impact of the pandemic. It is not difficult to imagine the toll that working over 60 hours per week in such a challenging environment might take on staff health and wellbeing, and the subsequent quality of care they were able to provide. It is crucial that we take this context into account when seeking to understand what BBC Panorama found, such as staff falling asleep while on duty.

7.28 Further analysis of the rotas shows that on any day at least one member of staff was working their sixth consecutive 11+ hour shift in Adult Forensic Services.

Staff support and development

7.29 Edenfield was, and remains, a complex unit which requires staff who are appropriately trained and supported. Staff need to have the skills and training to understand the population they work with and their needs, and to know how these needs are best met. It is the nature of these services that patients can respond violently when distressed; without a clear understanding of why people are responding in this manner, it can be difficult to deliver compassionate care.

7.30 Any ward needs to have a staff group with enough experience to manage the ward and to role model and support staff coming in new to the system. This is best achieved through:

- regular, effective supervision[23] that supports staff to do their jobs;

- regular reflective practice that they have time to attend, and which allows them to process their experiences and reflect on the dynamics and environment in which they are working;

- training that keeps staff up-to-date with contemporary practice and the core skills necessary for their roles;

- staff being led well and supported in the managing the complex tasks associated with keeping a secure ward safe;

- staff feeling that they are part of a team; and

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[23] "Clinical supervision is a formal process of professional support, reflection and learning that contributes to individual development." (Butterworth, 2022).

- staff having the time and resource to get to know the people for whom they have responsibility for providing care.

7.31 We have described clearly many reasons making care difficult, of which the most significant links back to dangerously low staffing levels. Fragmented working relationships among staff and a culture of repressing concerns further inhibited staff from managing their service effectively.

7.32 That said, some staff at Edenfield have received a lot of support in their career development. We heard of staff being supported to undertake external courses and accreditations, and of being promoted through managerial roles very quickly. We were told that the likelihood of being supported in this way related to a "*psychological contract*" in Edenfield which included: complying with maladaptive cultural norms and working practices (such as not raising concerns), not challenging unsafe practice or being seen not to "*cause problems*".

7.33 Staff were usually promoted from within the service, which meant limited external perspectives or opportunities to learn from elsewhere. Care group leaders and the former Chief Operating Officer had all come from Edenfield. Very junior staff had also been promoted quickly, and a perception emerged from our interviews that a number of these individuals quite quickly became 'out of their depth'.

7.34 The turnover of ward management in Edenfield has been exceptionally high in some cases.

Figure 14: Band 6 and 7 ward and deputy ward manager turnover, April 2020 to August 2022

Number of different ward/deputy ward managers on each ward (April 2020 to Aug 2022)
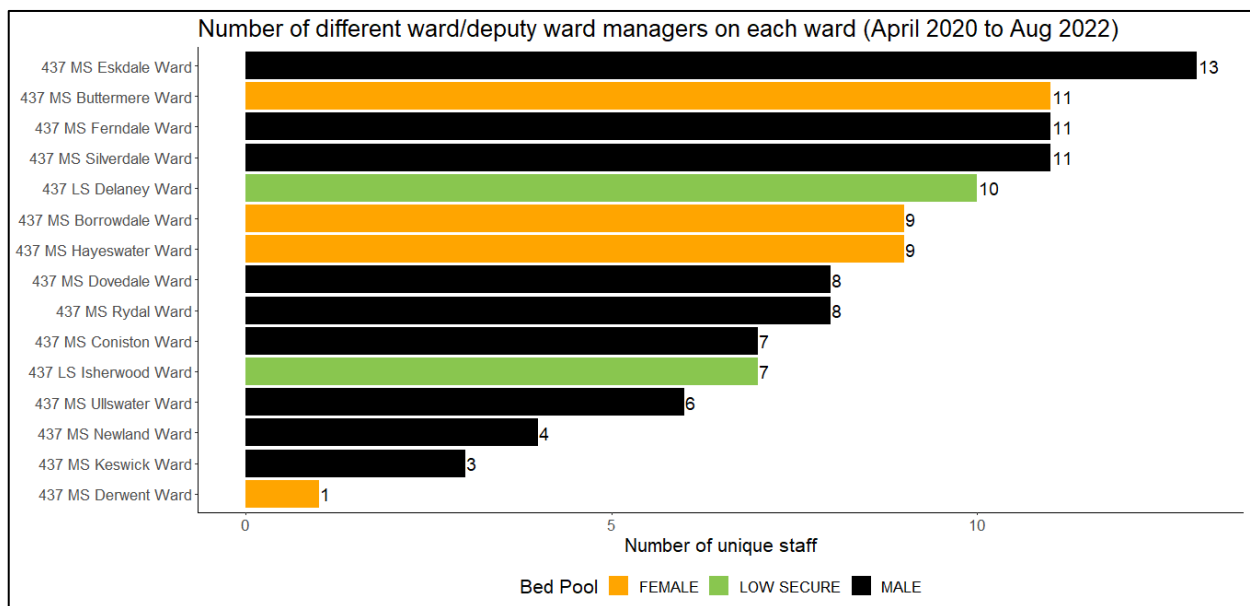
7.35 This has been most notable in Buttermere, Silverdale and Delaney wards, but has risen across almost all Edenfield wards over the last year.

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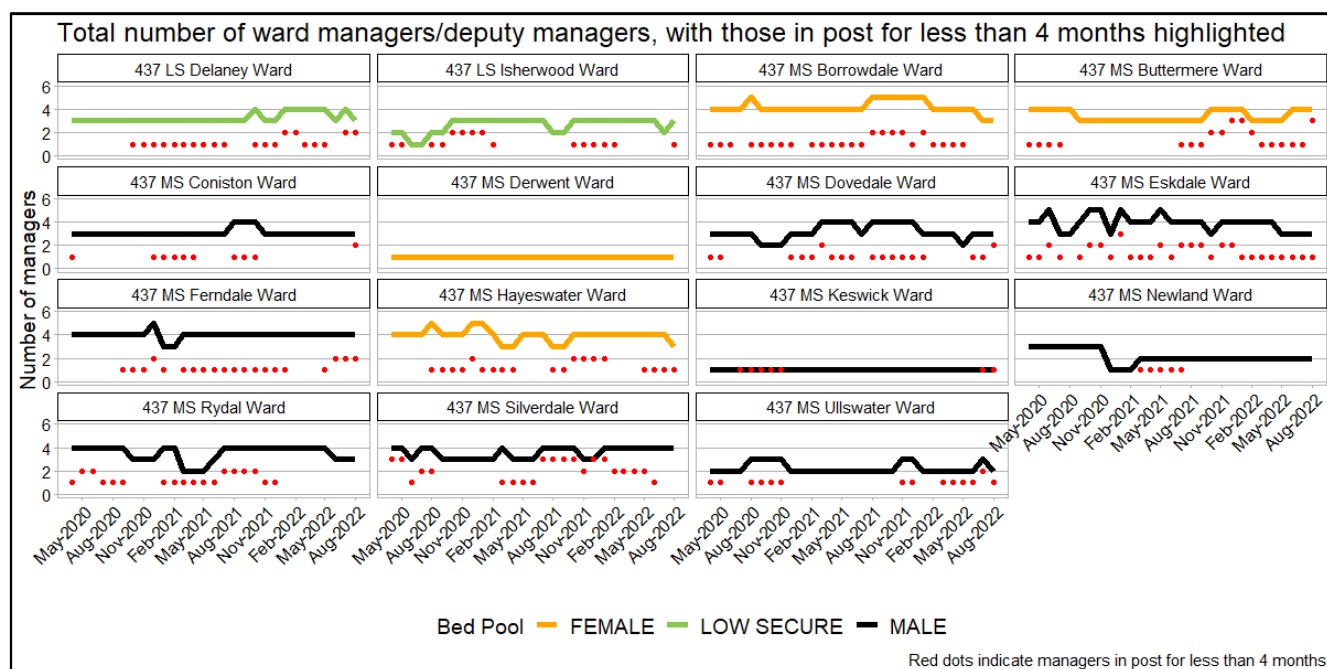
7.36 The average retention of ward managers was variable across Edenfield wards, although a clear pattern emerged that most wards had been unable to retain a manager for more than 18 months.

7.37 We asked for the organisation training needs analysis and received a nil return. Instead, the Trust shared its statutory and mandatory training modules. This list was five years old (dated 2018) and is therefore unlikely to reflect the latest guidance and good practice in relation to the modules it covers. It remains unclear what the training offer is for Edenfield (non-medical) staff to ensure that their practice meets the needs of the specific patient group.

7.38 Supervision in Edenfield has seen a marked drop in the last three years and now stands at 58%. Within this data there are some significant 'hotspots', including compliance at only 6% on Wentworth Ward. Temporary staff do not receive supervision. Good quality, regular supervision is key to delivering high-quality care and retaining staff. This is particularly true in a challenging and specialist environment such as Forensic Services. Conversely, low supervision rates risk staff feeling unsupported with their challenges at work or wellbeing, and management being disconnected from the realities for staff delivering direct care. Few staff reported to us a positive experience of supervision or 'on job support'. Only a few preceptees could describe having time with a preceptor and formally signing off competencies.

Insufficient knowledge and skills to manage service complexity

7.39 Staff at Edenfield often felt psychologically and physically unsafe in the delivery of their role. Insufficient supervision and support, coupled with a sometimes unkind management style, contributed to stress, burnout and ultimately the high turnover and absence of staff in the service. This is significant in considering how the conditions identified by BBC Panorama had been able to develop.

7.40 Staff working in secure services require specific skills and knowledge to develop the robust relational security required to care for individuals who have often suffered severe trauma and who can be of serious risk to themselves and others. These skills and knowledge require training over a number of years to develop and hone.

7.41 The clinical workforce at Edenfield had seen high levels of turnover across most disciplines, and difficulties in recruiting to these roles. We heard of year-on-year decreasing interest in jobs advertised in the service, which matches the picture in other forensic services and the health service nationally. We heard people describe a narrative that potential recruits knew that Edenfield

was not a good place to work. This led to the appointment of newly qualified nurses (preceptees) who had not gained the necessary experience to run a shift. We know that some of these preceptees quickly found themselves out of their depth, being the only registered staff member on a shift required to manage complex patients unsupervised.

Figure 16: Adult Forensic Services turnover rates by staff group, April 2020 to March 2023
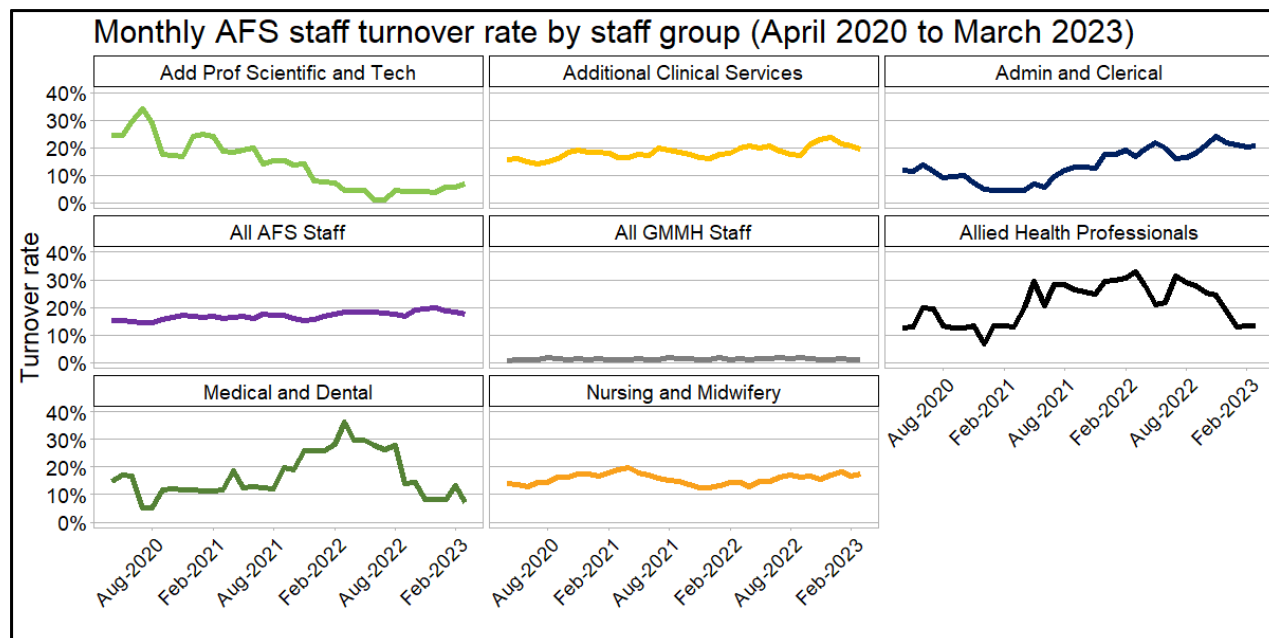
7.42 The charts above display the overall staff turnover rates in Adult Forensic Services by month and staff group.

Medical workforce

7.43 Stress among the forensic consultant group was clear when we started this review. Three senior colleagues were on sick leave or on phased returns and one of these individuals had collapsed with serious illness at work.

7.44 The Trust drafted in additional senior medical support to support the service post-Panorama; this included a very senior experienced medical leader from their own organisation and a second very experienced medical leader from an external organisation. These people were crucial in working with the new management team in stabilising the service, keeping it running and starting to make improvements in governance and delivery. Their capacity was extremely limited in the context of the enormity of the task requirement.

7.45 Many consultants showed obvious distress during our interviews. The relative inexperience of this group, their lack of processing of the experience of Panorama and worsening dysfunction within this group meant they were unable to provide the leadership and direction that this service needed to support its recovery. We made the Interim Chair and CEO immediately aware of this issue and suggested that they get the support required to commence resolution of these issues. This is crucial to allow the group to function effectively together and lead and support the improvements in Forensic Services. Consultants presented as a diverse group with differing styles and interests; this is a desirable situation and should have been a bonus to the service. Instead, their inability to disagree well and to develop a shared common purpose served to limit their functionality and further weaken the medical voice.

7.46 Described to us by consultants present and past, and by forensic psychiatric trainees who have witnessed it, the dysfunction in the consultant workforce has been long-standing and pre-dates the 2021 timeframe of the review.

7.47 This dysfunction had been recognised previously, but actions to address the issues did not resolve them. There was a lack of trust and at times incivility between colleagues, with descriptions of a medical hierarchy and lack of transparency about internal appointment processes. There was inequitable sharing of resources, whether this be the completeness of a multi-professional team or the allocation of training doctors. We heard of a perception that less experienced colleagues had the heaviest clinical burden and more newly appointed consultants were responsible for the most acute and most unwell patients. This came into sharp focus for consultants during the pandemic. It is often true that more senior colleagues have more management responsibilities and fewer clinical or less burdensome clinical duties as they progress through their careers. It is crucial that this is openly and transparently managed in a service, to balance the responsibilities and ensure that everyone has opportunities to learn, develop and progress their careers.

7.48 The turnover of medical staff is the most striking characteristic of this professional group. Since April 2020, nine consultants left the trust to work in other organisations or elsewhere within the Trust. The Trust has appeared to exhibit little curiosity in this turnover. Consultants described having to ask for an exit interview or having exit interviews that focused on persuading them to stay rather than understanding why they were leaving. One consultant described sharing all of their concerns in a requested exit interview and being told "*that's just your perception*".

7.49 Elsewhere in this report, we have given examples of Edenfield consultants' clinical decisions being over-ridden by managers. Others include:

- the removal of a patient perceived by the clinical team as having a high level of risk of violence from seclusion, without any discussion with the responsible clinician; and

- a manager querying the levels of escorts that patients needed while off the unit, and repeatedly suggesting that patients did not need to be on high levels of observations.

7.50 Trainees noticed a change in the way seclusion had been used over the time they had been training in GMMH. They described how, as more junior trainees, they would carry out seclusion reviews out of hours and that many seclusion rooms would be unoccupied. However, in recent times, the use of seclusion rooms had markedly increased.

7.51 Every consultant described difficulties in getting their voice heard about the issues they were experiencing, or indeed about the potential solutions they were proposing. One consultant said they tried to share their experience of working on a more highly functioning unit as a means of improving the service at Edenfield, to no avail. Another wanted to lead work to understand the culture of the service, but it was made clear to them that there was not a shared common view of poor culture in the service. Consultants responded in different ways to the experience of not being heard when they tried to speak up; while some stayed, a significant number chose to leave, particularly those who were newly appointed. Some had made their feelings known prior to the Panorama programme.

"*I felt like I was working in an evolving inquiry*"*, and*

"*I couldn't consciously stay as I did not want to become complicit in the drama.*"

7.52 GMMH and Edenfield lost many medical staff who had successfully trained and committed themselves to the service. Some of these had become frustrated and unwilling to tolerate the delivery of poor care and the impact this was having on their work life balance and personal mental health and wellbeing.

Occupational therapy

7.53 Both the occupational therapy team and the psychology team described not feeling valued by the service. They did not believe that the value that they brought to patients' treatment was properly understood by operational management colleagues and both described losing posts as part of annual cost improvement plans and not allowing for staff to be recruited to backfill colleagues on maternity leave.

7.54	Occupational therapists (OTs) said that they were often being counted in the ward staff numbers and described how some management colleagues viewed their role to be that of occupying the patients. They said they often stayed on to support nursing staff after their shifts were finished. Other colleagues have said that OTs were not able to carry out assessments of people's skills and needs and support patients with their rehabilitation needs. The OTs saw many experienced staff leaving and new staff being brought in with little investment in these new staff. They spoke of a focus appearing to be on quantity over quality.

7.55	They experienced a culture where staff were not encouraged to speak up and indeed described it as "*career suicide*" to do so. They described many violent incidents and little leadership to support staff to work well with challenging patients. There was frequent trading between patients on the wards, including of contraband items brought back following leave, that led to conflict between patients and staff and patients being hurt. They saw colleagues become demoralised and unable to take breaks. They described it as being "*bog standard*" for observations not to be undertaken correctly.

7.56	They described three different reviews of their services having been undertaken but said that they had never seen any of the outcomes.

Psychology

7.57	While the psychology department has had a reduction in whole time equivalent (WTEs) over the last ten years, it has been able to maintain an effective supervision and support structure for its team. There is considerable expertise within this team. They described some of the challenges that services featured in the BBC Panorama programme had experienced in the months leading to its airing. Three of their team had gone on maternity leave and there were insufficient staff to provide the service as intended. Arrangements were made to add additional support from elsewhere, but this did not match the deficit. The team were told that funding could not be provided to backfill these posts.

7.58	There has also been a lack of training in trauma-informed care. Prior to the pandemic, every staff member coming to work in the service had a day's training as part of their induction, and anyone working in the women's service had an additional two-day training in delivering trauma-informed care. During the pandemic all of this stopped. This coincided with the changes in the psychology team with ward-based psychology moving to team-based psychology. Training in trauma-informed care did not return as the psychology team did not have the capacity to facilitate this. The availability of this training is now being remedied but is not yet complete. Care was described as moving from a trauma-informed focus to a behavioural focus in this absence.

Pharmacy

7.59	Pharmacists play a key role in managing medicines safely and supporting patients to be well informed when considering and taking their medicines. Pharmacists work with nursing and medical staff to achieve this.

7.60	Low numbers of registered staff at Edenfield impacted their work. They described a lack of consistency in nurses' knowledge of their patients, and both this and the time taken to locate keys had an impact on how work was done. They also noted that the systems in place for ordering medications on the ward were inefficient, particularly in the context of low nursing numbers. There were concerns about low level medication errors and concerns about how many medication errors were reported, particularly during COVID-19. The department has recently appointed more staff to improve medicines safety, but at the time of this review, the pharmacy team were only able to provide input into 50% of the clinical teams working there.

Administrative support

7.61	There are high vacancy (30%) and sickness rates (11%) within the administrative team. This staff group is key to facilitating the smooth running of many aspects of clinical teams and especially consultant medical staff functioning. Forensic psychiatry and the role of the Responsible Clinician (RC) within this service require a large amount of statutory paperwork and multi-agency working. All

of this requires systems to ensure timely completion of these roles, meeting with families and carers, organising reviews, meeting with different statutory and non-statutory organisations and the support, preparation and sharing of associated essential information.

7.62   In reality, many of these activities have to take place whether or not administrative support is available. Essentially, if administrative support is not available, RCs end up completing many of these tasks themselves. This is an inefficient use of time, increases the risk of error and causes an unnecessary additional stress on the clinicians it affects.

The impact of workforce challenges on restrictive practice

7.63   Patients' human rights must be embedded in the delivery of care and always considered in the context of restrictive practice. To uphold human rights, providers must always assess and keep under review if there is a less restrictive option for the people they care for. We have defined restrictive practices earlier in this report; specifically, we are describing the use of restraint, segregation/seclusion and the use of rapid tranquilisation. In this review we are clear that restrictive practices cause harm to patients. They can have a marked impact on people's mental health, their physical health and emotional wellbeing, and for some patients these practices re-enact previous trauma. Therefore, they should only be used as a last resort when other avenues of support have been exhausted. The CQC report, Out of Sight – who cares? (CQC, 2020) highlights many of these issues.

7.64   Blanket restrictions fall outside this description but are of great importance in this environment. The National Mental Health Safety Improvement Programme (MHSIP) demonstrated that reducing unnecessary blanket restrictions resulted in marked reductions in the use of the restrictive practice described in this report.

7.65   There are a variety of resources available to trusts to support organisations to manage this practice well. These include the MHSIP and the Restraint Reduction Network (RRN) which created standards and assurance frameworks to support organisations in reducing and in managing these practices well. There are also powerful family voices, such as Aji and Conrad Lewis, the parents of Seni Lewis who died as a result of a restraint, who were instrumental in bringing the Mental Health Units (Use of Force) Act (2018)[24] into being. These families continuously strive to work with professionals to reduce restrictive practice.

7.66   Supporting and managing patients with distress and associated behavioural disturbance is a complex and highly skilled nursing intervention within a secure service, which should be supported by the wider multidisciplinary team. Anticipating and recognising signs of distress, distracting and de-escalation are complex but fundamental skills in a forensic environment. Working well with distressed people with the potential to become violent is heavily dependent on staff having the time, the skills and confidence to build trust and relationships with patients. These patients are often frightened, agitated, have a low tolerance to frustration and have mental states that can mean that they are viewing the world through a very different lens to when their mental health issues are better managed. The most significant finding in the MHSIP report was that the interventions that made the most difference to reducing restrictive practice in inpatient services were the ones that changed the relationships between the patients and staff.

7.67   Effective early interventions can significantly reduce the need to use restrictive practice. It is easy to see, however, that in a forensic environment with staff in insufficient numbers and not having the appropriate skills, they can become frightened and resort to using seclusion/segregation or restraint with patients who they feel unable to manage safely.

7.68   Once in seclusion/segregation it is an equally skilled intervention to assess and support people to come out of this restricted environment back safely to the ward environment.

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[24] https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales

7.69 Data from Edenfield suggests that they have had a higher-than-expected use of restrictive practices on their male medium secure and women's services. This is particularly evident within their women's services.

Figure 17: Seclusion incidents per occupied bed day over time at Edenfield, April 2020 to March 2023

Number of seclusion incidents per occupied bed day at Edenfield by ward type (Apr 2020 to Mar 2023)

Bed Pool — FEMALE — LOW SECURE — MALE
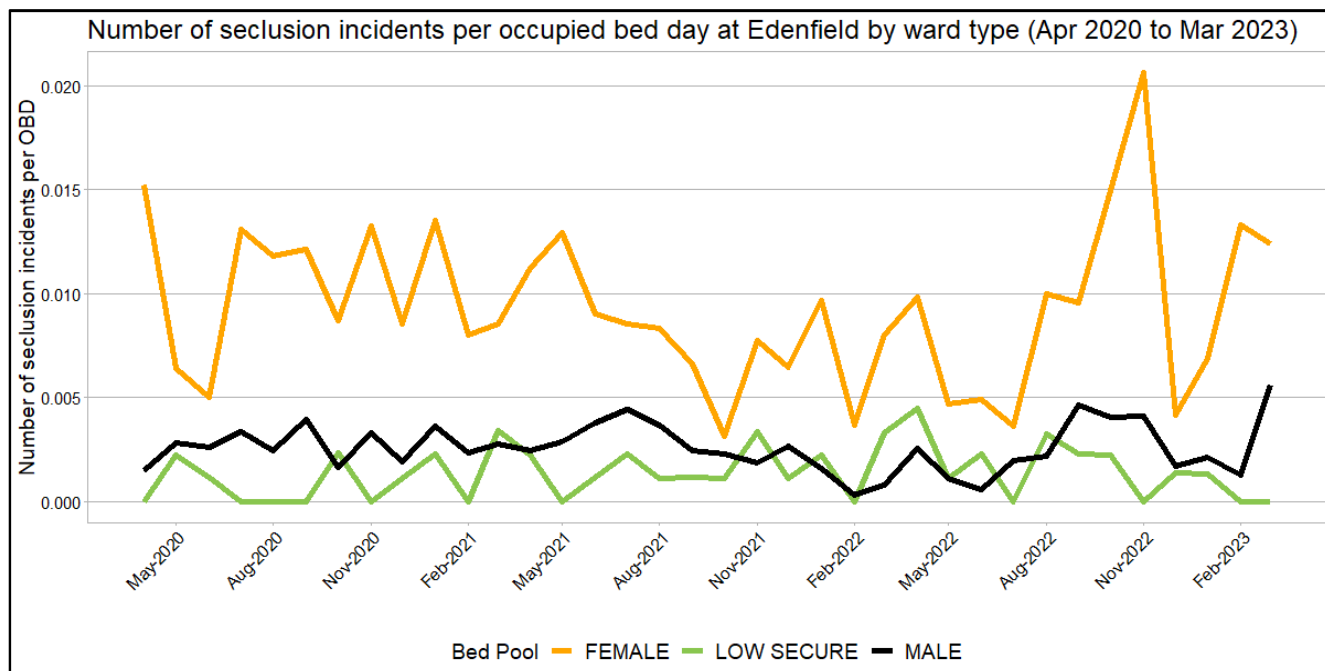
7.70 There also appear to have been a high number of prolonged seclusions/segregations.

Figure 18: Use of seclusion in Adult Forensic Services – length of episode

Distribution of seclusion episode lengths of stay (Apr 2020 to Mar 2023)
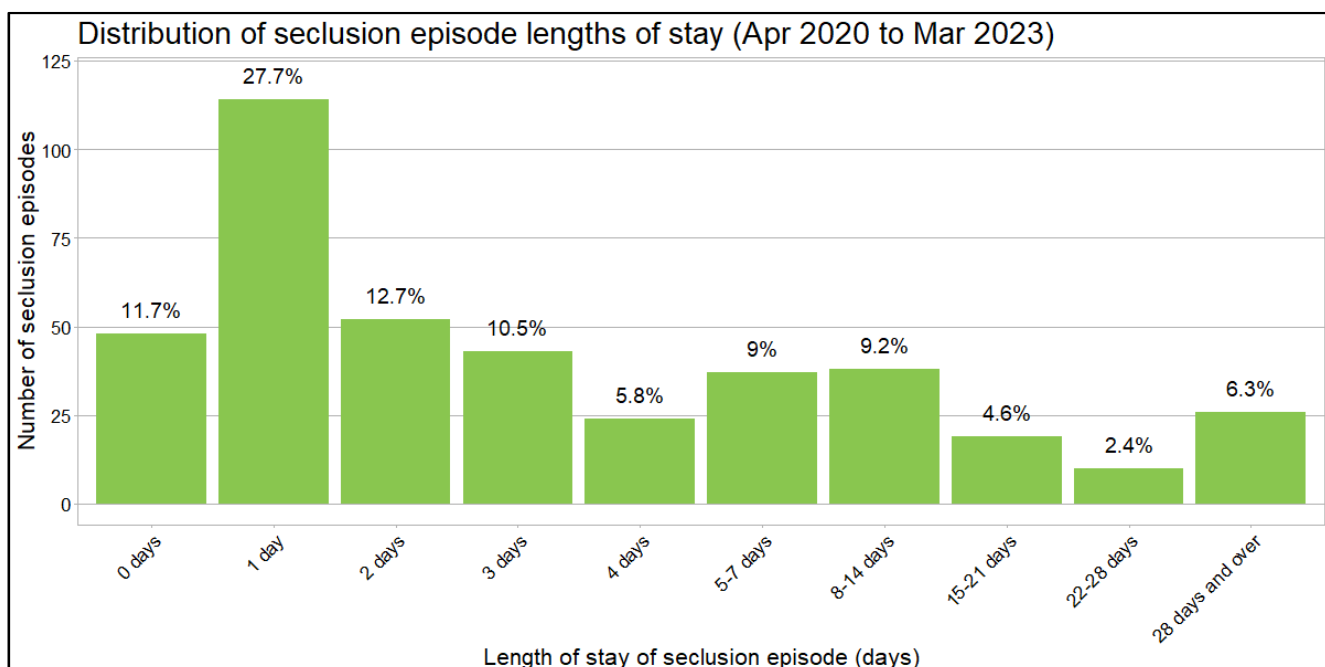
7.71 The average length of stay for the seclusion episodes was 8.8 days, with a median of 2 days, a lower quartile of 1 day and upper quartile of 7 days. The maximum recorded length of stay for seclusion was 257 days.

7.72 It is noteworthy that the Trust's Positive and Safe Practice Lead left the organisation in 2017 and was never replaced, with their role being subsumed into the role of a member of the PMVA training team.

7.73 The seclusion environment at Edenfield is of a very poor standard. We heard accounts of raw sewage leaking into seclusion rooms, and mould growing. We saw photographic evidence of some of this. Much of the environment we saw appeared to be poorly maintained. These factors had previously been reported, with little action taken until post-Panorama.

The impact of workforce challenges on care provided

7.74 Forensic services provide care and treatment for some of the most complex, high risk and vulnerable people using mental health services. When services are adequately staffed with professionals with the right skills, knowledge and experience, where teams work well together, information flows freely and the culture supports the delivery of high-quality, safe care, these are stimulating and rewarding places for both patients and staff. Not only do they provide the care that people need to recover, but they also provide a vibrant training ground for professionals to learn and discover the joys of working with the incredible people who use these services.

7.75 However, when this balance is upset, the voice of clinical staff is not welcomed (or is suppressed) and the focus on quality and safety is lost, these forensic services become frightening and hostile places for both patients and staff. The delivery of care really can become about "*surviving the shift*". Even the simplest tasks can become undoable and the more complex tasks of delivering trauma-informed care or maintaining the security of the ward are severely compromised.

7.76 Staffing levels, use of temporary staff, and the dilution of knowledge, skills and confidence over time have had a marked impact on how a nursing team complete the tasks that need doing on each shift.

7.77 In any shift there are a number of tasks that need to be completed. These range from tasks such as ensuring that patients have the necessary support to look after themselves and to keep their personal space clean and tidy, through to managing medicine administration safely, to the more complex forensic tasks of managing security on the ward. There need to be enough people with enough time to complete the task list and staff need to have the skills, knowledge and confidence to complete all of these tasks effectively.

7.78 We heard numerous accounts from every discipline and examples cited in reports from various sources to know that tasks were not safely and reliably completed. These range from the simplest to the most complex. Below are some of the issues which were identified in the quality reviews that were undertaken and fed back to leaders; however, little action was taken.

Concerns raised in the context of "*filthy bedding*" and messy and cluttered bedrooms.

"*staff feel afraid approaching/entering certain patients' bedrooms. Some wards feel uneasy. Staff are faced with patients displaying very aggressive behaviours. On the wards some staff fully occupied the offices and not the ward (almost a siege mentality)*"

"*staffing levels do not allow for tasks to be completed.*"

7.79 This review found that the most prominent staffing issue was that experienced by the nursing team. It was the issue that every clinician we spoke to described and it undoubtedly had a big impact on the quality, safety and experience of care within this service.

7.80 The value of the nursing expertise has dissipated over time to the point that nurses had become invisible. Nurses were not routinely considered as part of the multi-professional team. The difficulties with recruitment and high turnover of nursing staff, over time, depleted the service of forensic nursing experience. Nurses would be quickly promoted before they had gained the necessary skills or experience to fully deliver the more senior role. This, and the depletion of more senior nursing roles, led to less opportunity for supervision or mentoring from experienced skilled staff. We heard about a lack of adequate recognition, protection and clear process to support staff who were assaulted at work. The impact of these assaults on staff was not appreciated; staff did not feel cared for.

"*We need to get therapeutic levels of nursing care linked to outcomes rather than to a custodial level.*" (GMMH senior nurse)

7.81 The failure to adequately adapt to the national shortage of nurses and the impacts of COVID-19, alongside an operations management team who did not acknowledge (and at worst supressed) concerns from clinical staff when they were raised, led to a domino effect of deterioration within these services that started before the time period in this review and was accelerated by the pandemic.

7.82 Clinicians with longer affiliations to the service described a gradual weakening and breaking of academic links across disciplines and a loss of senior nursing roles.

7.83 Staff gain forensic knowledge and skills to do the job well from a variety of different sources: training, supervision and mentoring, and from doing the job in a team of other clinicians with more experience of the service, the ward and patients using this service. We have highlighted issues with lack of training for staff in restrictive practice and the reduced training opportunities in trauma-informed care. The knowledge shared among teams is an important and practical way of learning about how to do the job. As the skills, knowledge and experience of the workforce deteriorate over time, the tacit knowledge quickly follows suit. In this context, practice easily migrates away from best care and the ability to recognise what good care looks like diminishes over time.

7.84 Edenfield demonstrates that over time, staff are less reliably able to manage the core nursing interventions, from tasks such as supporting patients' personal space to be kept clean and uncluttered, to the more complex tasks of managing violence, aggression, and self-harm and relational security in ways that keep patients and staff safe. The use of seclusion is a poignant example of what can happen in these circumstances. If staff do not have the skills and confidence to manage well behaviour that challenges, whatever its origin, they are likely to resort early to secluding a patient.

7.85 Teamwork is crucial for effective safe care delivery; this is true from the top to the bottom of the service, from the senior management to the 24/7 care delivered by the nursing team. A strong consistent clinical voice is required at every level. This does not mean that staff should always agree with each other, in fact quite the contrary. In services managing complex patients there is a huge benefit to having professionals with different training and viewpoints who can challenge each other, robustly and respectfully, with a shared common purpose to provide safe, effective care in circumstances where a range of clinical management options are possible.

7.86 However, to achieve this requires that every person feels listened to and people need to have the skills to disagree agreeably and develop a consensus position that everyone can follow. We have seen that this was not the case in the medical consultant group, which led to the weakening of the medical voice and prevented this key voice being heard in the closed culture of this service. The multi-professional team at a service level has not included nurses adequately, if at all.

7.87 Within some services, the vacancies for other members of the multi-professional team and the turnover of consultant staff have compromised team functioning. The most extreme impact has been within ward-based nursing staff. Low numbers, high turnover, high levels of temporary staff and frequent staff movements have a marked impact on team functioning. Not only do these circumstances make it very difficult for nursing staff to get to know the patients they are responsible for, but they also impact upon the understanding of the dynamics between any combination of patients and staff. The experience of teamworking is crucial for safety in forensic services, as by their very nature they involve managing complex, often distressed, patients with a high propensity to cause harm to others and themselves.

7.88 Given that care was being delivered in this hugely challenging, and on occasion frightening and dangerous, context it is perhaps less surprising that care deviated so far from the expected norm. As a senior clinician within the service articulated:

"*People found their own way of managing demands placed on them which they were ill-equipped to cope with – by distancing themselves from clients too hard to understand and to whom the easiest response was denigration and dehumanisation*".

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7.89 The new management team have worked well to start to increase the number of nursing staff working within this service, and there is organisational development work to improve the functioning of the medical consultant workforce. There has been development and recruitment to more senior nursing staff in the service. Governance systems are beginning to develop to ensure that staff have a better understanding of how well they are delivering care.

7.90 However, as this service considers when it will be safe to reopen, specific consideration must be given to addressing the skill, knowledge and experience deficits, particularly in the nursing team. The medical leads within the service are relatively newly appointed consultants who will need high-quality supervision and mentoring to support the development of the skills and experience required for such roles. Failure to do so is likely to result in a recurrence of the problems previously described.

7.91 As the service redesigns and improves, a clear expectation and shared understanding of the values and behaviours that each member of the multi-professional team should experience from each other will be critical. This will also be required from the senior management team in their work with those delivering direct care and support. Particular consideration needs to be given to how consultants work together with ward managers to deliver the care to the high quality that the service aspires to.

7.92 Many staff with longer service working in Edenfield have described it as having been a flagship service in forensic mental care, and everyone would like it to return to this position. To achieve this there needs to be absolute clarity of 'what good looks like' in forensic services, an understanding of where the service is now, the gap between the two, and a clear, visible plan for how this gap will be closed. This process will need appropriate forensic expertise within the care group to develop and deliver. The expertise needs to be present at each level within the service: at the point of care delivery, within the supervision and mentoring support to staff, and at senior management level. Not everyone needs specific expertise, but there does need to be a shared common understanding of what is required. Edenfield has some senior clinicians with considerable expertise, particularly in psychology and medical teams. Consideration of how best to draw upon this expertise and experience will be an important part of the development process.

7.93 In this chapter we have talked about the importance of the workforce in delivering care; we will now move on to discuss the processes that the Trust has in place to check on the quality of care it is providing.

Chapter 8 Governance

Introduction

8.1 This chapter looks at how the Trust is run and overseen at its highest level, including by its board of directors and committees. We call this organisational governance. Governance is the system by which an organisation is directed and controlled (UK Corporate Governance Code, 2015). During the course of our review, we noted that the organisation was in the middle of implementing significant changes to almost all of its key governance structures and processes. For example:

- A committee restructure is currently underway, with significant changes to committee terms of reference and workplans being made. During our meeting observations, senior staff often stated that it wasn't yet clear where specific matters should report to.

- The Board Assurance Framework, which is a statement of the Trust's key strategic risks and how these are being managed, was being overhauled and was not being used effectively.

- There had been an operational restructure in 2022, moving from 11 divisions to four care groups, with a new collective leadership model introduced, with a fifth care group added for Adult Forensic Services after Panorama aired. The move to care groups means new information flows and different local governance structures.

8.2 In short, there was still significant work to be done to establish a well-used and tested governance framework[25] which would allow for clear flows of information from 'ward to board'. We noted that a significant proportion of the time in key governance meetings we observed during the summer was spent discussing how the governance would work better in future, rather than providing assurance on changes to practice that have been made, the impact of these on quality of care, and lessons learned.

The impact of the Board

8.3 The role of the board of directors in an NHS Trust (NHS Providers, 2015) is to:

- Set the Trust's strategy (understand how the Trust's strategy is being implemented and to hold to account for delivery of the strategy);

- Exercise statutory duties under the Care Act and NHS Constitution;

- Oversee the work of the executive team and management in ensuring that strategy is delivered; it does this by ensuring that the Trust's systems of control are robust and reliable;

- Set and lead a positive culture in the organisation (as discussed in Chapter 6 Culture); and

- Give account to the work listed above to key stakeholders, including the Council of Governors.

8.4 At the time of the BBC's investigation into Edenfield, the Board of GMMH, like many of its peers, was overseeing the Trust's recovery from the pandemic. In addition, four new non-executive directors started in 2022. Although two of the new non-executive directors had been in a governor role at the Trust, the Board lost a significant amount of its Board organisational memory at this time. Since Panorama, the Board's composition has changed even further. As outlined in Chapter 3, the external and strategic landscape has also lacked stability and has been challenging. This is not specific to the Board of GMMH but is reflective of the NHS agenda nationally. It is likely significant that the Trust also effectively doubled in size after 2017, when it acquired Manchester and then Wigan mental health services.

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[25] In this context we refer to a governance framework as the systems, process and controls which support board, corporate, operational and clinical governance.

8.5 That said, some of the systems and processes the Board was working with led to insufficient checks and balances to mitigate serious failings in care being allowed to happen, like those at Edenfield. Examples include:

- A notable lack of the voice of the patient in governance processes, including Board meetings. Patient stories, for example, were only re-introduced to the public Board in late summer 2023 after a significant gap. These have been consistent practice at most NHS trusts since the Mid Staffordshire public inquiry in 2013 (Francis, 2015). We observed little focus on patient experience at meetings of the Quality Improvement Committee (QIC) and noted that non-executive directors had raised this.

- The quality of Board papers has historically been poor, with data aggregated to a very high level and no obvious way of identifying potential 'hotspots'. Safe Staffing papers, until very recently, are good examples of this; there was no visibility at a ward level of understaffed services, and narrative contained in reports historically was sometimes inaccurate.

- Senior staff told us on various occasions that there was a clear expectation that reports for Board and committees were made 'palatable' and that positive news was underlined.

- On some occasions, there has been a notable lack of professional curiosity and probing of information presented to the Board. For example, the Trust's National Staff Survey results in 2021 and 2022 were extremely poor. We found little recognition of this in the Board and People Culture and Development Committee minutes, and Board members do not appear to have probed, for example, how the Trust's results compared with its peers, how the Trust was seeking to learn from the best to improve its results and what the results meant in terms of the Trust's culture of quality. During interviews, some Board members were quick to blame 'the pandemic' for these results. Even if this were true, the results are among the worst of all mental health trusts nationally. This did not sound the necessary alarm bells for the Board.

- As described in Chapter 9 on Organisational learning, some information regarding concerns at Edenfield had been reported to the Board and its committees months before the Panorama documentary was broadcast.

- Some non-executive directors told us that previously challenge has been suppressed, and that they had received feedback that they were "*overstepping*" or "*going too far*" with their questioning, which is likely to have stifled Board debate and important lines of enquiry being raised at Board.

- We heard that there was insufficient attention given at Board level to the impact of the expansion of the organisation, particularly in relation to culture, quality of care, and post-integration plans. We were also told that the expansion of the organisation did not have a corresponding investment in leadership or governance resource. It was not clear in our interviews with Board members that all of them were aware of this.

8.6 Commentary about Board cohesiveness and visibility (see Chapter 5) in the organisation have similarly limited the effectiveness of the Board in fulfilling its role.

Council of Governors

8.7 The role of the Council of Governors is "*to hold the non-executive directors individually and collectively to account for the performance of the board of directors.*" (NHS England, 2022). Governors are not directly involved in the operational management of a trust, and would not be expected to be directly involved in specific staff or patient issues.

8.8 We met with a group of governors to seek their views on the Trust. We offered two sessions and, due to the limited uptake, met once with six governors. Separately, we also met with the lead governor, and with three different governors as part of developing the terms of reference and received several items of correspondence from other governors.

8.9 The most prevalent theme emerging from our discussions was a strong sense that GMMH needs to put more emphasis on listening and responding to the voice of service users, carers and families, aligned to a greater focus on co-production, recovery and achieving better clinical outcomes. Many spoke of concerns regarding the culture of the Trust, which they felt lacked openness and transparency. A clear view emerged that this will be key to the organisation rebuilding itself and rebuilding trust with patients and the public.

8.10 Governors we spoke to were highly committed to the Trust. Most agreed that the period following Panorama had placed a strain on dynamics, both among governors and also between the Council of Governors and Board members. While this has been improving in recent months, there remains work to be done to ensure that the voice of governors is heard and responded to.

8.11 Some governors were frustrated by the discipline of governance processes in the organisation, including the lack of timeliness of meeting papers being circulated, inaccuracies in capturing minutes and a general sense that their contribution had not always been acknowledged or appreciated.

Committee effectiveness

Quality Improvement Committee

8.12 Quality governance should serve to support the organisation in identifying potential areas of concern, identifying learning and sharing themes across the organisation. It should focus equitably on patient safety, clinical effectiveness and experience of care. We observed the QIC twice, and its supporting executive-led group (the Quality Improvement Operational Delivery Group) once.

8.13 The QIC is chaired by a non-executive director and is the key assurance-seeking committee in relation to the Trust's overall quality of care. We are of the opinion that the non-executive director leading the committee chairs this forum effectively; however, there is poor discipline in relation to the management and administration of the committee, which fundamentally inhibits non-executive directors from discharging their roles effectively. In particular:

- Papers are issued very late and often, we understand, not at all. This means, in practice, that non-executive directors are unable to prepare adequately to hold the executive and management to account. Care group deep dive presentations (which represent the largest focus on the meetings) have until very recently not been circulated in advance.

- There is a dearth of data provided to the meeting to support assertions made in papers and presentations. It is unclear how members would be supported to gauge performance trends over time, benchmark quality performance or identify outliers from the data presented. Our observation of the discussion of a paper relating to ligature deaths in June 2023 found that no committee members raised the fact that ligatures had risen significantly in the last year, despite management providing positive assurance in the paper.

- There is a tolerance for papers not being issued for vague reasons, such as changes to process or format, including key papers such as Safe Staffing (not sent to the June meeting), despite this being an extreme risk for the organisation. When asked about this in interviews, relevant personnel described the poor discipline around submission of papers as normal practice.

- Meetings are held virtually via MS Teams, which has become normal practice in the NHS since the pandemic. This, however, appears to have given rise to some informal practices which inhibit good governance. For example, we observed the chat function being used for members and attenders to continue debating previous topics, which is distracting and leads to important debate which is un-minuted. A key example in this area is a non-executive director using this chat sidebar (during the June 2023 meeting) to urge management to ensure that the Trust is being "*open and transparent*" in relation to its management of serious incidents. This would not be minuted.

- The committee is a significant outlier in its lack of consideration of patient experience data. We observed non-executive directors highlighting the lack of this on various occasions, although plans to remedy this remain unclear.

- While we did observe some useful points of challenge from non-executive directors, there remains significant scope for development in this area, with a focus on ensuring that demonstrable improvements are being made for patients. For example, a paper on deaths of children and young people in Prestwich has been submitted to the Board and QIC on various occasions due to non-executive directors being unhappy with its content and clarity. Repeated re-submission of assurance reports is highly unusual and is reflective, in our view, of a need for non-executive directors to be more decisive in their challenge and to more stringently hold management to account when standards and transparency fall below those which patients and the public would expect.

8.14 Similar issues apply to the key subgroup of the QIC, the Quality Improvement Operational Delivery Group (or QIODG). Papers for meetings are sent out very late (the day before the meeting in June). Again, there is a high number of verbal items which means that members are unable to prepare questions or hold each other to account for agreed priorities. Items we would expect to be core areas of focus in a meeting of this nature, such as risk registers, a quality dashboard, audits, patient experience reports, safe staffing intelligence and quality improvement updates were absent.

8.15 We understand there are various other senior quality related forums, and a Quality Risk and Assurance Group is also being introduced. We observed various conversations in which senior personnel expressed confusion about "*what is going where?*" and scope for duplication or gaps. Again, this represents in our view, a distraction from focusing on changes to practice in direct care.

People, Culture and Development Committee

8.16 The People, Culture and Development Committee (PCDC) oversees the delivery of the overall workforce strategy of the Trust which includes staffing, organisational development and education. We observed the PCDC and its supporting executive-led group, the People Delivery Group (PDG) once.

8.17 The PCDC is chaired by a non-executive director and is the key assurance-seeking committee in relation to all aspects of workforce. Similarly to the QIC, the meeting is well chaired; however, the poor meeting discipline and administration inhibit its effectiveness. For example:

- We observed the last-minute non-attendance of an executive director which resulted in two important papers not being discussed.

- As with QIC, papers are issued late and not all attenders had read all the papers in advance. We also observed the chat function being used for members and attenders to continue debating previous topics, which is distracting and leads to important debate which is un-minuted.

- While there was a large amount of data presented, it was not presented in a way which would help those who attend to grasp easily what the data meant. This means that there is a risk that attention will not be appropriately focused and actions may not be the most effective.

- Some items are presented as verbal items at the last minute, which means that non-executive directors cannot prepare questions or useful contributions in advance. We observed a degree of frustration about this in PCDC and other forums.

- We observed a lack of clarity about the role of PCDC and QIC in relation to seeking assurance on safe staffing levels. Given the scale of risk associated with this issue, it is key that the governance processes around this matter are clarified.

8.18 Similar issues apply to the key subgroup of the PCDC, the PDG. Projects to address staffing lacked detail on outcomes or reflection on what had been achieved already and therefore there was no consideration of how achievable the target was. We note the lack of a Recruitment and Retention Strategy to draw together and clarify this work. Not all professional groups who attended the

meeting contributed. Some of those who were attending appeared to be typing and various apologies were sent to the meeting.

8.19 Neither the PCDC nor its subgroup had identified signals that there was a problem at Edenfield, namely:

- significant staff shortages;

- high turnover of nursing and medical staff;

- very poor staff survey results; and

- high sickness rates.

Commissioning Committee

8.20 GMMH became the lead provider (LP) for adult secure services for Greater Manchester on 1 October 2021. The Board of Directors/Commissioning Committee assumed delegated responsibilities for clinical oversight and quality assurance from April 2022. The Commissioning Committee was set up as a board subcommittee with a delegated non-executive director Chair and Executive Director Lead to ensure that there was separation between the Trust as a provider of adult secure services and its role in commissioning as LP, which is essential to avoid conflicts of interest.

8.21 This committee's responsibilities were:

- Strategic planning and service development, with responsibility for addressing health inequalities.

- Clinical oversight, including pathway management.

- Quality assurance and improvement for all low and medium secure provision within Greater Manchester.

- Contractual, financial and informational oversight for all providers.

- Financial planning and budget management for the whole low and medium secure provision for Greater Manchester.

- Delivery of Long Term Plan targets and commitments for populations with learning disabilities and/or autism.

8.22 In reality, our review of meeting papers and minutes, as well as our observation, found that limited attention was given to service quality at this forum. This was inhibited, in our view, by the historical lack of clinical attendance at the meeting. It took the committee until March 2023 to state that they were proposing recruitment of a medical lead for the LP. The nominated nursing representative was not always in attendance, and where a deputy was nominated, they also did not attend.

8.23 The Trust made preparations to take on the responsibilities of the lead provider, with a Board Development session held in July 2021 to understand the role of commissioning responsibilities prior to delegation and a statement of readiness for the Board in September 2021. In reality, however, it appears that the role of the committee may not have been well understood, or that its function was not made a priority. This may be in part due to these being new arrangements for many organisations nationally. For example, planned meetings of the committee have not always taken place and meetings have been cancelled, and a decision was made to reduce quoracy due to individuals not always being able to attend. There was a missed opportunity to explore this further, with consideration given as to whether the meeting had the right attendance, its role was well understood, and what the potential impact may be of the lack of a strong expert and clinical voice at the meeting.

8.24 A member of our team attended the June 2023 meeting, where there was a Quality Lead (a social worker by background) who had started to identify data requirements to measure service quality.

While the Trust had made preparations to assume this responsibility, this was in the early stages. There was no other clinical member of staff present. The Trust has told us that further work has been undertaken to strengthen the approach, following the publication of national guidance.

8.25 The meeting was well chaired by the non-executive director and all present contributed well. It was evident that there was some work to be done to understand the role and functioning of the committee, particularly when dealing with quality issues within the lead provider's own organisation. For example, there was a discussion on whether GMMH was acting with sufficient pace to enact improvements. It was unclear what ethical walls had been put in place to ensure sufficient impartiality in discussions of this nature, particularly given that the committee is chaired by a GMMH non-executive director. These issues are not unique to GMMH, and a number of provider collaboratives are facing the same issues. This report and its findings offer an opportunity for others to take stock and review their processes.

Service-level governance

8.26 Governance at a service level is at various stages of maturity across the organisation. At Edenfield, clinicians told us that there had historically been a lack of data and intelligence for them to measure the effectiveness of their service. This has recently been addressed.

8.27 Services like Edenfield will escalate information as required to their relevant care group. Care group governance remains in development following the restructure. Our review of the former Specialist Services Care Group governance meeting minutes found insufficient attention given to quality and service risks. In some instances, quality had simply not been discussed due to it being scheduled at the end of a busy meeting agenda.

8.28 Regardless of the effectiveness of governance structures and processes, psychological safety and a learning culture are key to governance being able to support improvements. If service managers and leaders feel unsafe in escalating concerns and issues, information will continue to be stifled and service safety will suffer.

Summary

8.29 The Trust's governance framework has not functioned effectively in raising serious quality concerns to the Board and its committees, including those from Edenfield, in a timely way, to support safety and improvement. In our view, there were several reasons for this, including:

- a lack of helpful information available to frontline clinicians to help them understand the quality of care they were delivering;

- the absence of a culture of healthy escalation, with staff often too fearful to pass on 'bad news';

- unclear roles and responsibilities across committees, alongside a lack of grip;

- insufficient focus on quality at Board level; and

- insufficient rigour and probing of the information presented to key forums.

The Trust told us of the work it is undertaking to strengthen its governance framework which includes reviews of its committee structure and responsibilities. A new Equality Diversity and Inclusion Committee and a Service User/Carer Council are in the process of being established.

8.30 We have described how the Trust oversees quality in this chapter: next we will look at how the organisation learns and makes improvements.

Chapter 9 Organisational learning and responsiveness

Introduction

9.1   Part of our review was to understand how well the Trust learns when things go wrong. We wanted to make this as concrete as possible, so we chose a small number of case studies to look at, where clear concerns had been raised. We looked at:

- how the organisation (and its partners) responded to concerns raised by a patient in its secure services;

- inpatient deaths through suicide, and the extent to which the organisation was responding to, and learning from, these tragic events;

- how the Trust responds to and learns from Prevention of Future Deaths reports; and

- the Trust's improvement plan, and how well this enables learning.

9.2   The purpose of this chapter of the report is to assess whether the Trust can demonstrate the capacity to learn from concerns and incidents using real-life examples. All of these cases represent significant learning and improvement opportunities for the Trust, not least where GMMH patients have tragically died. While the case studies in themselves may have taken place across different services or sites, we nonetheless have found commonalities in the Trust's management of significant issues being raised to them. These are:

- **Pace of change** – Some of these issues are very long-standing, and yet improvements are difficult to identify. Some actions identified following the death of a patient in case study 3 have not been implemented almost three years on. The improvement plan already has overdue actions. Similarly, ligature incidents, in spite of the reduction plan, continue to rise. This is, in part, reflective of the need to create a more empowered workforce who are able to make the changes necessary at a service and patient level.

- **Lack of transparency and/or clarity in reporting** – Across case studies 1, 2 and 3, we found that management information (whether in the form of incident reporting, quality metrics or Board/committee reporting) has been opaque. In all three cases we looked at, it was difficult to get to the heart of the issue or what had actually happened. In case study 1, this was because language used to communicate to key forums was vague and unspecific. In the case of inpatient deaths, the baseline position and how this benchmarks to similar organisations was, and remains, unclear. In case study 3, it has been very difficult to ascertain who knew what, and when, in the incident response.

- **Poor governance processes, including consideration of the need for impartiality** – Across all three cases we found that there would have been benefit in having greater independence when reviewing the issues of concern. External perspectives may have identified more learning opportunities and better managed any real or perceived conflicts or risks to impartiality. Of particular concern is the fact that the internal review in case study 3 did not explicitly describe the falsification of records which was later reported.

- **Lack of scrutiny of key information** – Across case studies 1, 2 and 3, we found a need for more effective scrutiny of information presented to key forums, including review of key information by qualified and relevant clinicians. There is also a need for clearer and more coherent responses from management and executives to challenges posed by non-executive directors. Openness and transparency are critical conditions if the Trust is to create a culture conducive to improvement and learning.

- **Issues treated in an isolated way** – Across three of the four cases we looked at, we found examples of issues being identified without their being considered as potentially systemic. This risks them being treated locally, without management getting to the underlying cause of an issue. For example, we found no evidence to suggest that the treatment of the patient in case

study 1 was not happening more systemically in other inpatient services. Similar examples are reflected elsewhere in this report, including issues of racism and discrimination at Park House.

- **Rigour in the monitoring of change** – There has been a tendency for the organisation to be overly optimistic in its reporting of changes made since all of these events. This has, on some occasions, been challenged by senior staff or non-executive directors in the organisation, but we also found examples of key information being missed, which would suggest that existing plans are not having the desired impact and may be putting other patients at risk of harm. In case study 3, actions relating to observations remain incomplete almost three years after the death of the patient. A further example of the weakness of oversight of improvements is that the agreed audit of observations has not been happening as planned. The improvement plan does not always identify outcome measures which would really enable leaders to be assured that changes have been made and sustained. There is a risk that, by focusing on 'action', the Trust is not sufficiently looking at 'outcomes' and the differences made for its patients.

9.3   Below we describe each case study in turn, what we found, what happened and how the Trust (and, where relevant, its partners) responded, and what this tells us about the Trust's ability to learn from adverse events.

Case study 1: Concerns raised by a forensic inpatient

9.4   In June 2022, a Forensic Services patient made several allegations against the Trust. These were very similar in nature to those seen on Panorama in September 2022. This gave the Trust and regulatory bodies a significant period in which to act before they were aware of the broadcast. In this section, we sought to follow the allegations through the various layers of governance and communications to identify what actions were taken.

9.5   What we found was the following:

- A number of the issues raised by the patient were minimised or omitted in reports, and where actions were identified, we can find little evidence of them having been taken. A number of authors of reports gave us examples of being asked to change their report before presenting it to the relevant committee/board.

- It is clear that concerns about at least one ward in the relevant service were raised at the Trust Board, the Quality Improvement Committee and the Commissioning Committee; all of these have executive and non-executive members. All Trust committees appear to have accepted assurances that actions were being taken without appropriate challenge.

- There was a lack of consistent leadership in this particular ward, with six ward managers within an 18-month period. A review of the patient's segregation which was intended to be 'independent' was undertaken by a close relative of a senior member of staff in the service.

Background

9.6   The patient was admitted to Edenfield from a psychiatric intensive care unit. Progress reviews had been held every other month via Teams during the pandemic by the case management team, and numerous professional meetings had happened, which had included a number of internal and external partners. The clinical team at Edenfield had raised several concerns about their capacity and ability to meet the patients' needs and provide the best care for the patient. All agreed that the patient no longer required a secure pathway. A discharge was planned into supported accommodation.

9.7   The Greater Manchester Adult Secure provider collaborative is led by GMMH. A provider collaborative is a partnership between two or more providers to work at scale for the benefit of their population. GMMH was designated as the lead provider and, as such, held responsibility for the contract which included monitoring the quality of services. This was overseen by the Commissioning Committee within the Trust which was chaired by a non-executive director and was a subcommittee of the Board. They took responsibility for the quality of service provision on 1 April 2022, and

therefore the case managers[26] transferred to the Provider Collaborative Quality and Commissioning Hub at this time.

Timeline and commentary

9.8 6 April 2022 – A routine 'safe and wellbeing review' was completed for the patient. This is part of a national programme which checks the wellbeing of all people with a learning disability or autism diagnosis held in a mental health hospital. This identified that the patient was being nursed separately from their peers in what amounted to long-term segregation, which had not been recognised by the Trust. This led to an independent care and treatment review[27] (IC(E)TR) being commissioned. An IC(E)TR was booked on 29 June 2022, and it was agreed in the interim that GMMH would carry out a review of the segregation.

9.9 14 June 2022 – A formal complaint was made by the patient via their advocate to the Trust that staff were provoking them and pulling faces at them. It also detailed that they had been forcefully pulled into the seclusion area by multiple members of staff and that the level of force was unnecessary. Other incidents are alluded to. This complaint states that an earlier complaint made by the patient had taken in excess of a year to be responded to.

9.10 23 June 2022 – An 'Independent review of the use of long-term segregation' was carried out for the patient. The review was carried out by a former member of the Adult Forensic Services senior leadership team (SLT). This individual's close relative remained a member of that SLT. From a governance perspective, this does not meet best practice and may lead to questions regarding its objectivity (and stated independence of the review). Nevertheless, the review is comprehensive in nature and does encourage the ward team to look for the least restrictive options. It notes that if the patient is to remain segregated from their peers, then they are to be moved back to the Annex. This is a separate part of the ward that was historically used as a multipurpose activity space but was converted later to a bed area.

9.11 29 June 2022 – The IC(E)TR was carried out, during which the patient made several allegations relating broadly to 'bullying and mimicking/taunting' by staff. The list of allegations was long and detailed, including individual named members of staff taunting the patient; for example, saying that they were in seclusion because they are a baby, making a gun-like gesture to their head through the seclusion ward window and many more. They also highlighted some of the general restrictions and disruption on the ward, such as a lack of continuity in psychology staff, the ward environment being noisy, and a general lack of care.

9.12 The concerns raised in the IC(E)TR were so serious that the review Chair escalated them to the GMMH Adult Forensic Services SLT the same day. The IC(E)TR Chair notified the case manager the following day and confirmed they would be informing the NHS England Improving Quality team in the Learning Disability and Autism Programme, the NHS England NW Specialised Commissioning Nursing team and the CQC.

9.13 30th June 2022 – The Senior Case Manager met with the patient, safety was assured over the weekend and an alternative placement was sourced. The patient was moved to the new placement on 4 July 2022.

9.14 The relevant executives were informed of the allegations and a meeting of the Quality and Commissioning (Q&C) Hub senior leadership team took place, attended by representatives from NHS England Specialised Commissioning. A number of actions were agreed, including a full review of the patient by the Senior Case Manager and a review of the service to be undertaken by the Q&C Hub.

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[26] The role of the case manager is to ensure that the service where a patient is placed is able to meet their needs and that the care plan is supportive in doing this. They also have a quality monitoring role of the provider.

[27] An IC(E)TR provides the opportunity to check that a patient's care and treatment are effective, the least restrictive possible, and that they are supported to leave hospital as soon as possible.

9.15 At this time, the Trust also indicated that formal investigations would be carried out on the individuals the patient had named in their detailed allegations.

9.16 1 to 6 July 2022 (written up on 20 July 2022) – A quality review of the service was undertaken by the case managers. The report described the following 11 themes and asks for assurance from the Trust:

1. **Staffing** – low numbers, lack of continuity and high sickness. Senior managers reported as not visible, and no action was taken when issues were raised with them. Staff reported no career progression, and many were actively seeking alternative employment.

2. **Environment** – a number of environmental issues were noted.

3. **Training and reflective practice** – a lack of training in learning disabilities and autism awareness. Some reflective practice was available.

4. **Care planning** – some care plans were sparse with no collaborative feel, with some noting instructions like 'minimum 24 hours in seclusion'. Some were more collaborative in nature.

5. **Restrictive practice** – significant examples of blanket restrictions were found.

6. **Seclusion** – advocacy noted prolonged periods of seclusion with few exit strategies.

7. **Use of PRN** – specific inappropriate examples of use of pro re nata (PRN) medication (prescribed for when they are needed rather than at set times) were noted on some wards.

8. **Equality and diversity** – the review identified a number of issues and wanted to see evidence of the Trust's values in practice.

9. **Freedom to speak up** –the review wanted to see evidence of opportunities to raise concerns with the leadership team or appropriate professionals including the FTSUG.

10. **General** – some patients echoed similar culture issues flagged by the IC(E)TR around staff interactions with patients. Two further patients on one ward described being sworn at and spoken to in a derogatory manner, and some patients described access to leave and restricted items not being supported depending on their engagement.

11. **Efficacy of the service** – the review wanted assurance that the service is in line with national aspirations.

A list of actions and assurances was requested from GMMH.

9.17 6 July 2022 – A briefing note was sent by NHS England to Directors of Learning Disabilities and Autism and Mental Health (presumably at NHS England) regarding the concerns raised about Edenfield. The NHS England Regional Director with responsibility for Mental Health and Learning Disability did not receive the letter and was not informed about it. The briefing states that, during an IC(E)TR, the person reported to the panel that staff bully and taunt them and gave several examples. It noted there were gaps in their care, a 'closed' culture on the unit, a safeguarding referral had been raised and that the case manager had visited. It reported that other patients had described similar experiences of bullying from staff to patients. This memo was not received by the NHS England Regional team.

9.18 The briefing then set out regional and national actions, which included the following:

1. escalation to senior managers within the hospital;

2. a safeguarding referral;

3. that the person has moved;

4. the regional lead, provider collaborative and ICS are all aware;

5. the case manager has visited; and

6. the Mental Health Act Reviewer from the IC(E)TR panel has escalated within the CQC.

Under the headline of 'Next steps and recommendations' the document notes that a senior intervenor[28] had been allocated to the person, and that the CQC is currently undertaking an inspection of the provider. The CQC completed its inspection of Forensic Services between 14 and 16 June 2022 (before the IC(E)TR). The well-led inspection[29] took place between 5 and 7 July 2022.

9.19   13 July 2022 – The Specialist Service Divisional Leads meeting was briefed, noting only concerns about staffing, environment, and the service model. No reference is made in the brief to the specific allegations. It notes that they are awaiting a written response from Specialised Commissioning.

9.20   18 July 2022 – The Commissioning Committee met for the first time since the allegations were made. As described above, the Commissioning Committee is a subcommittee of the Board, chaired by a non-executive director, and attended by an executive of the Trust and a second non-executive director. There is no specific item on the agenda regarding these allegations, but within a presentation on *Management of Failure/Quality Concern Scenarios, one bullet point notes "Concerns raised by an Independent IC(E)TR chair regarding the care of an individual patient placed with the lead provider which led to wider quality issues being identified"'*. Two of the non-executive directors present described being alarmed by this and questioned further what exactly this meant. They were so concerned that they felt they should raise the issue as part of the report to the Trust Board.

9.21   20 July 2022 – Two preliminary investigations were undertaken into the allegations made by the patient. No formal action was recommended.

9.22   25 July 2022 – The Chair of the Commissioning Committee reported to the private part of the Trust Board that a safeguarding referral had been made following an IC(E)TR in the service. They highlighted the process the Commissioning Committee and Q&C Hub were undertaking. The Board discussed the roles and responsibilities of the various committees in overseeing the matter and resolved that the Quality Improvement Committee[30] (QIC) should have oversight of any significant incidents occurring in GMMH provider commissioned services. The QIC Chair confirmed that they would review the incident at the August committee.

9.23   3 August 2022 – A formal response was sent to the Quality and Commissioning Hub from the service, by way of a letter. Many of the issues raised are noted as already completed (such as environmental issues, advocacy, PMVA training). Other issues were noted as being part of an action plan (including a project on care planning); the letter also included details of how the service had escalated the inappropriate nature of the admission to the unit. It also noted that an investigation into the allegations was currently underway.

9.24   8 August 2022 – A high level plan was produced with actions and leads identified to address most of the issues highlighted in the review of the service. It noted that an investigation was to be undertaken into the specific allegations made.

9.25   A first draft of a report for the QIC was produced and reviewed by the relevant executive. Some amendments were requested as a result of this review.

9.26   10 August 2022 – Specialist Services Divisional Leads Meeting – No direct reference appears to have been made to the action plan and progress against it, although some of the elements were discussed, such as the environmental works.

9.27   14 August 2022 – The QIC met and a paper broadly outlining the concerns raised by the review of the service was presented. This had been submitted late and not included in the meeting papers, so it is unclear if members would have had time to read this in advance of the meeting. The specific allegations initially made by the patient are not included in the report, nor are some of the

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[28] Senior Intervenors are independent experts who works to find solutions that may be preventing the individual from moving on to less restrictive settings.

[29] https://www.cqc.org.uk/sites/default/files/20200115_Trust_wide_well_led_inspection_framework_V7.pdf

[30] The Quality Improvement Committee is a subcommittee of the Board charged with oversight of all quality issues within the Trust.

confirmatory patient accounts of staff swearing at and bullying patients. It notes an action plan was underway with much work already completed.

9.28   30 August 2022 – The action plan was updated; it is evident that there were conflicting views regarding progress that had been made, with several comments by a senior member of Adult Forensic Services staff noting limited progress. Corporate nursing were asked to support a review of care, and a visit was planned by a senior nurse for early September; however, as they did not receive a reply to agree their visit, this did not go ahead.

9.29   9 September 2022 – GMMH received a letter from the BBC regarding allegations to be aired, including a long annex of witnessed events.

9.30   13 September 2022 – GMMH was due to feedback about IC(E)TR concerns and GMMH response to the provider collaborative. This was stood down, due to the requirement to address urgent issues raised by Panorama.

9.31   25 October 2022 – Email from a non-executive director to the Trust Chair expressing concern at the lack of transparency and that the breadth of the issues had not been shared at the previous Board or QIC meeting.

Commentary

9.32   On 29 June 2022 a patient made a number of allegations about their care and treatment to an IC(E)TR. As part of this case study, we have followed those allegations as they made their way through the governance of the organisation. A number of things were evident:

- The seriousness of the allegations was minimised and aggregated into generalised concerns as they passed through various forums and committees. Furthermore, the outcome of the two preliminary investigations into alleged bullying did not fully acknowledge the experience of the patient who had raised serious concerns. It could be argued that, without the attention of two non-executive directors at the Commissioning Committee who noted some concerns as part of a wider presentation, the allegations would not have been raised to the Trust Board or QIC. As outlined elsewhere in this report, we heard on a number of occasions where authors of reports were asked to change the tone and emphasis of reports for senior committees.

- Board members had information about the concerns on one of the wards in Edenfield available to interrogate at the Commissioning Committee of 18 July, the Board meeting of 27 July, and the QIC of 11 August.

- Part of the action plan included undertaking disciplinary investigations into the named individuals for taunting and bullying the patient. We have been given various accounts as to who undertook these investigations. We were told by one member of the Adult Forensic Services SLT that Human Resources had told them there was 'no case to answer' so the investigations didn't proceed. We were later supplied with two 'fact finding' investigations which do not uphold the main body of the allegations, and no further disciplinary action is identified. We can find no assurance that this was followed up by any of the committees that were charged with overseeing the concerns raised.

- The issues passed through various forums and action plans were produced, but little change happened. The updated action plan of 30 August includes annotation by a member of the Adult Forensic Services SLT noting that some of the claimed progress in the first iteration needed revisiting. The matter was referred between committees, before QIC took responsibility for overseeing the case. A non-executive director felt obliged to email the Trust Chair in October to note that the action plan and report had not been to the Board or QIC.

- The CQC and Specialised Commissioning were aware of the allegations. Specialised Commissioners sent a briefing note nationally regarding the allegations to all Directors of Learning Disabilities, Autism and Mental Health. This was not received by regional NHS England. The CQC were aware, both from the Chair of the IC(E)TR and from NHS England who had informed them about the allegation and the extent of the patient's claims.

- Due to emerging concerns, NHS England explored with the ICB whether there should be a single-item risk meeting to discuss these with the Trust in July 2022. This meeting did not happen, as the system already had an imminent planned meeting, known as the Quality Surveillance Group. In addition, it was highlighted that CQC was, at that time, inspecting GMMH. It was also underlined that where concerns had previously been raised by the system in relation to GMMH CAMHS, some partner agencies in the system had taken assurance from the positive published CQC report.

- The provider collaborative, commissioners, regulators and Trust Board each had disparate pieces of information or intelligence available to them about quality concerns in this service. These had not been 'pieced together' by these partners to understand what they were telling the system about the quality of care at Edenfield.

- There is no evidence the CQC's inspection of the Forensic Service in June 2022 led to it having serious concerns. The CQC did raise concerns with the Trust about ligature risks, but these concerns were not considered serious enough to be included in the s29A Warning Notice[31] that was sent to the Trust on 6 July 2022 about environmental concerns in acute inpatient services. For example, there is no direct mention of the service in the CQC's feedback letter to the Trust following the completion of its well-led inspection in July 2022.

- Concerted oversight and increased requests for assurance appear to have commenced after the broadcast of Panorama.

Case study 2: Inpatient suicides

9.33   The second case study we looked at was inpatient deaths through suicide, and the extent to which the organisation was responding to, and learning from, these tragic events. What we found was the following:

- There is a lack of clarity regarding the information and data relating to inpatient suicide and ligature deaths presented within the Trust.

- This leads to a lack of clarity about the current position on inpatient suicides and ligatures that the Board and its relevant committees can scrutinise and challenge. This makes it more difficult for senior leaders, including non-executive directors, to be assured about the actions and progress the Trust is making.

- There is a lack of understanding of the data that the Trust has available, and this may lead to a disconnect with their suicide/ligature reduction improvement plans and assurance of progress against the plan.

- There is an opportunity to strengthen the existing ligature reduction plan with a more systematic approach. This can be achieved by paying greater attention to workforce, culture, hearing the voice of the patient and family, and the implementation of key policies such as the observation policy.

Background to the concerns

9.34   We were made aware of concerns regarding suicides within inpatient services. During the review there were also two inpatient deaths, likely to be from suicide, with at least one further serious incident where a patient was unconscious and required transfer to the intensive care unit at a local hospital. All three incidents were because of the patient using a ligature to a fixed point that was weight-bearing.

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[31] CQC a warning notice under section 29A of the Health and Social Care Act 2008 when they identify concerns across either the whole or part of an NHS trust or NHS foundation trust and decide that there is a need for significant improvements in the quality of healthcare.

9.35 Reducing ligature points is important in mental health inpatient settings as they are directly linked to an increased likelihood of death, with the majority of inpatients (80%) dying by hanging and strangulation (National Confidential Inquiry into Suicide and Safety in Mental Health, 2022).

9.36 The CQC has previously reported that the Trust was not always adhering to the relevant safety standards regarding the safe management of ligatures and, since November 2021, has required the Trust to make several improvements. Initially, the CQC issued a requirement notice in November 2021 following an inspection of the Trust's mental health acute wards for adults of working age and psychiatric intensive care units, stating:

'The Trust must ensure that all wards have an up to date ligature risk assessment and ensure that these are reviewed in line with trust policies and procedures. The trust must ensure that staff are aware of and consider all ligature risks on the wards. The ligature risk assessments must be meaningful and useful for staff.'

9.37 Since then, the CQC has highlighted a number of further concerns in relation to the Trust's management of ligature risks and its ability to make the required improvements at pace. These are set out in the communications and reports listed below:

Figure 19: CQC communications with the Trust regarding ligature risks

Date of inspection	Date of Action	Service	Action
13–17 June 2022	17 June 2022	Acute inpatients and Adult Forensic Services	The CQC fed back to Trust leaders their concerns about the management of ligatures and environment.
13–17 June 2022	6 July 2022	Acute inpatients/PICU	s29A Warning Notice
5–7 July 2022	24 Nov 2022	Well-led inspection	Inspection report published
16-17 Nov 2022	18 Nov 2022	Woodlands Hospital, Older people's inpatients ward	s31 Letter of intent: considering urgent action
16-17 Nov 2022	20 Dec 2022	Woodlands Hospital, Older people's inpatients ward	s29A Warning Notice
Jan-Feb 2023	17 March 2023	Acute inpatients	s31 Letter of intent: considering urgent action
Jan-Feb 2023	21 April 2023	Acute inpatients	s29A Warning Notice
31 Jan-6 Mar 2023	21 July 2023	Whole Trust	Inspection report published: '*We had significant on-going concerns in relation to how fire safety and ligature risks were not being effectively managed and mitigated on some wards we inspected. These were issues we had raised in our previous inspection which had resulted in the issuing of a Section 29A Warning Notice.'*

9.38 To better understand the current position regarding inpatient suicides, we asked the Trust for information relating to inpatient deaths through suicide and its response to deaths by ligature.

9.39 The Trust's Learning from Deaths Annual Report presented to the Quality Improvement Committee in July 2023 showed the Trust's own assessment based on the National Confidential Inquiry into Suicide and Safety in Mental Health (2022). This report states:

"*GMMH has been ranked as one of the 10 trusts with the highest patient suicide rate for the years 2017–2019. However, this does not necessarily reflect a safety problem within the organisation but potentially indicates something to be investigated by clinical risk and suicide prevention leads.*"

9.40 A separate report to the same committee meeting contained benchmarking data on inpatient deaths. It stated:

"…*data up to 31st March 2022 shows GMMH was not an outlier in terms of number of deaths, or rate of deaths, in inpatient bed types when compared to other mental health trusts. More recent internal data from the Mortality Report also confirms that unexpected deaths of inpatients are uncommon. In the 3 years to 31st March 2023, 12 deaths that were suspected to be inpatient suicides were recorded, out of a total of 38 unexpected inpatient deaths that occurred in a ward environment.*"

9.41 We also received information from the Trust training department regarding the ligature audit tool training, which stated that:

"*There are on average 19 suicides involving ligatures on inpatient wards in the UK each year – there were 5 inpatient suicides in GMMH involving ligatures in 2022… This means that, during 2022, the Trust had 26% of ligature deaths for the whole country!*"

This quote from a training slide within the Trust shows an awareness of the high numbers of inpatient suicides. We wanted to understand these statements in more detail and requested some further information on inpatient suicides from the Trust. We were provided with the data below:

Figure 20: All inpatient deaths as a result of taking own life
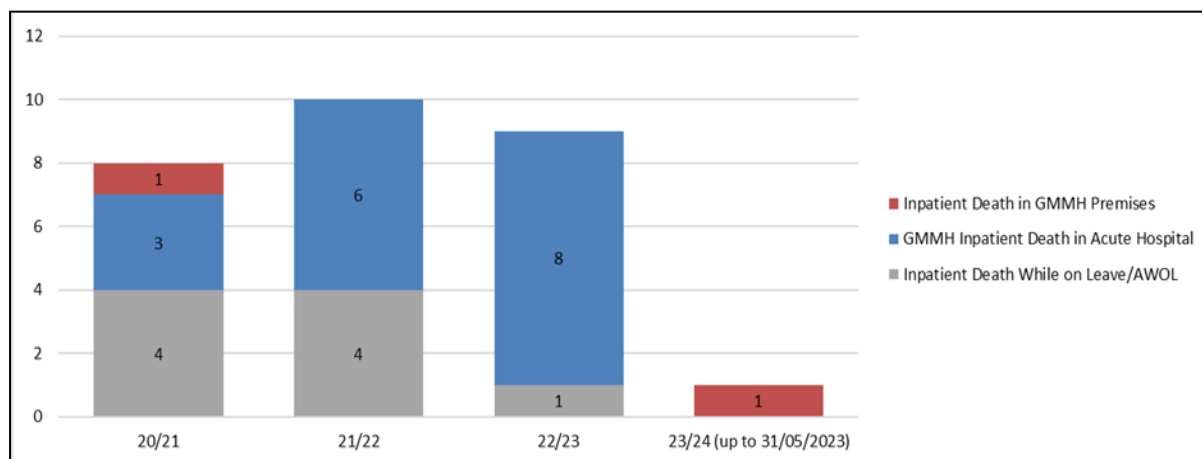
9.42 We were advised that the deaths in acute hospitals were patients under the care of GMMH that, as a result of an act of self-harm on a GMMH ward, sadly died when subsequently transferred to an acute hospital.

9.43 We then reviewed monthly incident reporting sent to the QIC. This report in July 2023 stated that:

"*Ligatures continue to be used as a way to self-harm and there [sic] 43.55% of the self-harm incidents reported during May can be attributed to inpatients using ligatures. The Trust has had 10 deaths of inpatients where ligatures were used since January 2022, with the number of inpatient deaths by ligature by year - 2021 = 2, 2022 = 6, 2023 = 2*"

9.44 We requested information from NHS England to compare with the Trust data. This showed some inconsistencies with information provided to us by GMMH.

9.45 In summary, the Trust provided us with various pieces of information in relation to suicide, inpatient deaths and ligature reduction. The information showed that there was no significant reduction in inpatient deaths and an actual increase in deaths by ligature in 2022. This information was not always easy to understand, based upon the various reports provided.

9.46 The Trust had begun to implement plans to address the actions required of it; however, during our review, we remained concerned at the pace of the delivery of those planned actions. In relation to the information outlined above, we were also curious about how the Trust may be interpreting its own information with slightly different perspectives, depending on the author of the various reports.

9.47 When we asked key staff how the organisation was responding to concerns raised around ligatures, we were told that a 'deep dive review' was commissioned at the March 2022 Risk Management Committee, and an outline proposal was confirmed to do this at the Trust Ligature Group in April 2022. The deep dive reviewed data from a two-year period and identified themes arising from ligature-related incidents, along with actions aimed at addressing these.

> The key themes identified from ligature incidents by the Trust were:
>
> - Safe and supportive observations
> - Accuracy of clinical rationale for level of clinical observations
> - Staff understanding of responsibilities when undertaking observations including recording
> - Handovers in respect of levels of observations
> - Changes being made to observations where decisions have not followed policy
> - Timing of observations and predictability
> - Clinical risk
> - Staff awareness of types of ligatures and risks
> - Risk assessment and formulation
> - Professional curiosity
> - Awareness of escalation of risk, rehearsing, informing someone
> - Anniversaries and significant dates
> - Checking out and sharing risk information with carers and families
> - Consideration of diagnosis and impact on risk
> - Recognition of escalating risk, changes in types/frequency of self-harm

In response to their review and under the direction of the Trust Ligature Review Group, they identified a number of actions, as set out below.

> **Actions reportedly implemented by the Trust**
>
> 1. Information page on its staff intranet specific to ligatures. This has links to environmental ligature risk assessments specific to the individual inpatient areas.
> 2. Work around storage and maintenance of ligature cutters, including a Trust-wide safety alert[32].
> 3. The Ligature Policy was revised and republished in August 2022. Ligature cutter specific training, including an educational video, was developed and is available on the staff intranet.
> 4. Ligature awareness, and the use of ligature cutters, has been added to the Trust-wide breakaway training.
> 5. A Trust-wide learning event in relation to management of ligature risks took place in July 2022.

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[32] This was one of the Trust mechanisms for sharing learning internally.

9.48 In addition to these actions, the Trust told us that ligature risk in inpatient areas has been recognised within the Trust improvement plan with several actions included. These are:

- Review and, as required, update ligature audits across the Trust to ensure all risks in clinical areas and in low risk/communal areas are captured.

- Review and update ligature risk audit tool.

- Assess ligature risks associated with hand towel dispensers and soap dispensers and agree plans to replace or mitigate.

- Implement strategy to address all current prioritised high risk ligature items in 2022/23 capital programme.

9.49 The Trust told us that there is a schedule in place for ligature audit reviews across the year, prioritised according to the level of risk within each inpatient area.

9.50 The Trust internal auditors undertook a Ligature Point Risk Review which was issued to the Trust in April 2023. The auditors gave an opinion of limited assurance. The review found:

"*The Trust had a Ligature Policy in place which detailed the key roles and responsibilities with regards to ligature risk management. The Trust utilises an annual ligature audit/risk assessment process at ward level with all areas found to have undertaken the assessments. Issues were however identified in relation to the outputs and local and strategic action planning and monitoring of issues identified from the ligature audit/risk assessments. Risks were not found to be clearly triangulated with incident data and capital considerations for prioritisation, action and implementing and feeding back into the risk assessment.*"

It is not clear how the outcome of the audit was conveyed to the Quality Improvement Committee.

Commentary

9.51 The Trust is now working to address the concerns regarding inpatient deaths, including those deaths by ligature points. There now appears to be a much clearer focus on resolving the concerns regarding these tragic events. The focus of the Trust has benefitted from the NHS England Mental Health Support Team who are able to provide additional expertise in this area. The Trust has provided ligature tool audit training to 104 members of staff in May and June 2023. Evaluation of the training shows that staff felt more confident in using the audit tool, which is used to identify and manage the risks of potential ligature points.

9.52 We are aware that in 2023, the Trust was told by NHS England about concerns regarding their approach to reducing inpatient deaths and specifically the ligature reduction method. These concerns were raised with senior clinical leaders regarding the pace and effectiveness of the Trust's response. A number of recommended actions were proposed to help support this work. We are unclear if all of these actions have been accepted by the Trust.

9.53 While recognising the general commitment from the Trust, we believe there are areas that remain of some concern. We have seen that the CQC raised concerns regarding the management of ligatures with the Trust in 2021 and several times since then. We also note in the most recent CQC report in July 2023 they stated that:

"*During this inspection we found some ligature and anchor points had been removed on some wards, for example, paper and soap dispensers, curtain rail tracks were replaced. However, some ligature points remained, such as not all toilets or en-suite doors had been replaced. The action for the uncompleted items in the ligature audits were documented on the maintenance reporting system as "*job to be submitted*". There was no timescale for completion. Senior leaders and ward managers discussed the priority criteria but there was not clear evidence of these being chased or followed.*"

9.54 We have listened to a range of GMMH staff and those who are there to support them. There is further room for improvement in developing a more systematic approach to ligature reduction. We heard and witnessed some differences across services and on occasion, on the same wards,

regarding the reduction of ligatures. This was most obvious on our site visit to Park House, acute inpatient services, where there were differences in the implementation of ligatures standards. We do note the aged estate on this site, and the plans for a new-build hospital to move out of Park House. The staff we spoke to were unable to give a clear rationale for the approach that had been taken by the Trust. We also heard from staff that the current training provided to clinical leaders on ligature reduction felt somewhat inconsistent.

9.55   While the ligature reduction plan is positive, there is more work required to ensure there is sustained improvement across the Trust. This should be focused on both ensuring a safe environment, alongside having sufficiently skilled staff present to support patients. We make observations elsewhere in our report regarding the workforce challenge and how this impacts on service safety. We know that lower staffing levels, lack of experienced staff and supporting high levels of people in acute distress can affect clinical staff's ability to always feel able to follow Trust policies relating to the observation of patients.

9.56   We reviewed the various data packs and reports presented to Trust committees and found scope to be more explicit about the scale of the existing risks, and how the Trust's performance in this area is or is not improving over time. There is an opportunity for the Trust to learn from others about how to present data in a more helpful way to enable organisational learning, and to understand if what is happening in GMMH is similar to what is found in other mental health trusts.

9.57   We did not always observe effective debate and scrutiny of this data. During our observation of the Quality Improvement Committee meeting, assurance was provided to the committee that the ligature reduction programme was making positive changes and that the CQC's warning notice in this area was likely to be lifted. The data presented to the committee stated that there was a 50% increase in suspended ligatures resulting in deaths and a significant increase in ligatures overall in-year. This was not challenged by members of the committee. This was an important opportunity to discuss the effectiveness of the plan as it suggests that the number of deaths has actually increased alongside the work of the action plan. There may be a lack of understanding of the data they have available, and therefore, this may lead to a disconnect with their improvement plans and assurance of progress against the plan.

9.58   The important work of the Quality Improvement Committee was likely compounded by various reports presenting the same or similar information sometimes in different ways. For example, the July Quality Improvement Committee had three different reports, all of which provided some information about inpatient suicides. This makes it more difficult to be confident regarding what the facts are. In trying to establish what is happening across the Trust, we found variation between the data the Trust provided and that shared with us by NHS England. This is likely indicative of a lack of clarity regarding what is happening within the Trust and how the system has responded.

9.59   Our analysis of this data in comparison with data available from the National Confidential Inquiry into Suicide and Safety in Mental Health (2022) (NCISH) suggests that GMMH accounted for approximately 11% to 15% of all inpatient deaths in England. This analysis must be caveated with the fact the time periods being compared are not the same and no adjustments have been made for differences in inpatient characteristics or other potential variables. The results nonetheless would indicate that GMMH may be atypical, and this requires more detailed analysis. The NCISH identifies that since 2015, on average, 19 deaths occur per year on inpatient wards. Acknowledging that these are small numbers, this would again suggest that the GMMH position is higher than expected.

9.60   We make observations elsewhere in our report about the lack of capacity across corporate services to focus on quality and sustained improvement. We think this still remains a factor and impedes the ability of the Trust to both understand what is happening and develop a coherent response. This lack of capacity likely meant that some of the senior clinical leaders who should be scrutinising this information were not able to do so effectively. In turn, this makes it more difficult for non-executive directors to understand and challenge the data presented to them.

9.61   At an organisational level, this has meant that the Trust struggles to learn when things go wrong, and has not been able to make the improvements needed at a pace that reduced the likelihood of further harm occurring.

9.62 The death of any patient under the care of NHS services is a tragedy. Deaths that occur on inpatient services can feel more profoundly distressing and patients, families and carers expect inpatient services to be a place of safety.

9.63 GMMH is trying to reduce the possibility of further deaths and has developed a plan to address these concerns. The plan could be strengthened and be more systematic in its implementation. This can be achieved by paying greater attention to workforce, culture, hearing the voice of the patient and families and the implementation of key clinical policies including the observation policy. We set out above that we have some concerns about the ability of the Trust to maintain pace and progress in making sustainable changes. We are also concerned about the Trust's ability to ensure that, where concerns arise, the Trust can check whether the issues are happening elsewhere and take the required action.

9.64 We have undertaken an initial analysis of the number of inpatient deaths. Due to the nature and timescale of this independent review we are unable to form a definitive view on whether this is commensurate with comparable organisations. Our initial view is that GMMH would appear to be atypical. The Trust has confirmed that following further review of the data by the Medical Director they acknowledge that they are an outlier for the number of inpatient deaths.

9.65 We have not looked at deaths in the community but several clinicians we spoke to raised concerns about community services and unexpected deaths. Further work is needed to fully understand these areas.

Case study 3: Death of a person in the Trust's inpatient care

Introduction

9.66 The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths. Organisations are required to respond to a Regulation 28 report within 56 days of the date of the report. Regulation 28 reports, while not in themselves a judicial sanction, are a formal instruction to make improvements to protect life and if not implemented could lead to judicial action. Between January 2020 and February 2023, GMMH received 17 Regulation 28 reports.

9.67 This case study involves the tragic death of a person using the Trust's inpatient services. The purpose is to review how the Trust manages Regulation 28 reports and how the Trust's learning systems work. This review looks specifically at the use of observations and the Trust's internal management of abnormal blood results. We do not comment on the treatment plan for this individual, but focus our commentary on the governance processes. This review is limited to understanding how the organisation understood and managed those issues.

Summary

9.68 We found:

- The time taken between the identification, investigation, and implementation of improvement action in response to concerns has been considerable and is still not complete, two years and ten months after the event. There has been a change in the process for managing an abnormal blood result. This change includes a standard operating procedure and accompanying flowchart to support managing abnormal blood results safely. This change happened sometime between November 2022 and September 2023 (24 to nearly 34 months after the event). The Trust identified learning relating to the practice of observations in response to this event; however, there doesn't appear to be any substantial change to the Trust's current observation policy that relates to learning identified by the Trust in this case. One of the actions was that audits of observations would take place. The audit was not implemented with a supporting process and audits were not always being carried out. This had not been identified and the group with oversight had been told the audit was being implemented.

- A three-day report and an immediate management review undertaken within six days of this incident happening clearly state that there were no training or competency issues with regards to nursing staff undertaking the task of observations. All staff had been trained and their competency in this area tested prior to the incident. In the immediate aftermath, a member of the nursing team admitted to falsifying observation records. Subsequently, it was found that a number of the nursing team failed to follow the Trust's observation policy and falsely recorded observations in the medical records; this led to disciplinary proceedings for this individual. The management review recommended the need for a wider Trust inpatient audit to determine whether the poor practice they identified, of failing to record observations, was a practice present more widely in the Trust. It does not appear that this recommendation was enacted. This was a missed opportunity to uncover a practice subsequently identified at Edenfield. The management review does not specifically describe concerns with the falsification of records. However, we are aware that there are other concerns of this nature elsewhere in the Trust. The Trust did not give any recognition to the staff member who confessed to their falsification of the record.

- Despite this timely management review stating that there were no issues with staff training and competency in the Trust's observation practice, and the issue instead being related to a failure to carry out the task and then to falsify records, the focus of the Trust's improvement work was on improving the observation policy and staff training in delivering it. This was a missed opportunity to properly understand why staff were not carrying out the policy and then falsifying observations. We are aware that issues with observations have been mentioned by the coroner in other cases.

- Staff disciplinaries took place after the initial management review and, as a result, three staff were dismissed. Two appealed and were reinstated; the third individual did not attend the disciplinary and did not appeal. In both appeals, the staff member's inexperience was identified as a mitigating factor and the appeal panel also had concerns about evidence used in the original disciplinary panel: "*the audit concluded that there was not a negative culture around observations.*"

- A serious incident investigation was carried out by an internal team ten months after the tragic incident. The sole recommendation concerning observation practice was that staff should be reminded of the importance of adherence to the Trust's observation policy.

- The serious incident investigation also made a recommendation to change the process of the acute hospital reporting back abnormal blood results to the inpatient unit. A Trust-wide safety alert was raised internally two months later (2021) to effect that change. This was issued 12 months after the serious incident happened.

- In the seven days after this Trust-wide safety alert was communicated, clinical concerns about the robustness of this proposed solution were raised and discussed by senior clinicians in the organisation via email. An alternative proposal was made that was considered to be a more robust and reliable solution. These concerns do not appear to have been acted on until at least a year later (2022/23).

- The coroner's inquest took place two years after this tragic incident and identified concerns about staff inexperience on the unit. It also raised concern that the Trust had missed an opportunity to properly understand the problems with observations. Despite the inexperience of staff on the unit having been a mitigating factor in the appeals staff made against their dismissals, the Trust took no action on this in their response to the coroner, citing their processes only.

Timeline commentary and additional relevant Information informing these conclusions

9.69 Background: in 2020, a person sadly lost their life while using an inpatient service within GMMH. The cause of their death was a physical health problem.

9.70 The three-day report comments that in the aftermath of this incident, a member of staff had confessed to a member of the management team that they had failed to undertake observations as

per policy but had signed to say that they had completed them, thus falsifying this record. Action was taken to communicate to staff about completing observations as per policy, clarify the role of the nurse in charge and undertake a review of the practice of allocation of observations. Audit processes were put in place to understand this practice more widely within this ward over the subsequent month.

9.71 The Trust put an automated response to an email address to improve communication.

9.72 An internal management review of observations was carried out six days after the event. This was completed by GMMH staff who were not part of this specialist service at the time they carried out their investigation.

9.73 The summary of its findings was that it was considered that there were enough staff on duty, but that some staff on duty on the day of the incident and, on further investigation of other days, some other staff did not carry out observations as per GMMH's observation policy. The staff identified included substantive qualified and unqualified staff and NHS Professionals staff. The investigators also reported that every member of staff had completed observation training and had their competency checked.

9.74 The only reference to probable falsification of records was:

"…*following a review of the observation sheets it was found that on the day of the incident the observations were not completed by all staff, namely 4 identified in CCTV footage and although the sheets were signed as being completed on the day of the incident it does not appear they were signed for contemporaneously as the Trust policy demands they should be.*"

9.75 This management review recommended that the staff who had failed to adhere to the Trust's observation policy should proceed to a disciplinary hearing. These staff were already suspended from duties. Changing the process of observations on the unit was suggested. The review also described increasing audit activity and retaining all CCTV footage for future scrutiny. In addition, it suggested reminding all staff of their responsibilities around completing observations, a change to induction training, and that this learning should be shared across the organisation. It also recommended that regular audits be undertaken of observation practice and CCTV footage retained.

9.76 In response to this management review, changes were made to the practice of observations on this unit alone. This included adopting a process from another similar unit, where the nurse designated the role of security undertook observations for their shift. It also recommended auditing observations and retaining CCTV footage to allow practice to be checked. This investigation also resulted in three staff proceeding to disciplinary management investigations on the grounds of gross misconduct (2020). Falsification of records was identified in these disciplinaries.

9.77 Three staff were investigated and disciplined. Two were dismissed but appealed, the third person did not appear at their disciplinary and so was dismissed in their absence and did not appeal. In 2021, the two preceptee members of nursing staff who appealed were reinstated. Within these appeals, mitigations to the original decisions were identified; these included concerns about skill mix on the day of the incident, and that the appeal panel had concerns about the conclusions of the observations audit used in the original disciplinary hearing. The appeal decision said: "*the audit concluded that there was not a negative culture around observations, the panel had some concerns about this*" and that no consideration had been given to the staff member who confessed to their error.

9.78 Later in 2021 (ten months after the event) an internal serious incident root cause analysis (RCA) was completed by staff employed within the Trust. This investigation considered the management of blood results. It described issues with communication between services that resulted in extreme difficulties in relaying crucial information to a clinician who could act promptly on abnormal blood results. Recommendations were made to remedy this.

9.79 The RCA also considered problems with patient observations; there was one reference to probable falsification of observations. This investigation confirmed that all staff were trained and competent in

delivering this skill and a recognition that the unit had put in place additional assurance using an audit within this service around observation practice. A recommendation was made that staff must adhere to the observation policy.

9.80   There was an associated action to share these findings in a learning event in the next eight weeks. It is not clear whether this learning event ever happened.

9.81   In 2021 (two months after the RCA) the Trust issued a safety alert re blood forms. This covered the recommendation made in the RCA report to ensure that when blood forms were filled in, they included the name of the unit/ward where the patient was placed.

9.82   In the days immediately after this alert, an email trail from senior doctors within the service to more senior medical staff raised concerns about the recommendation/safety alert suggesting that this was an unreliable solution and would not safely solve the problem identified. These emails identified that the abnormal blood result must be received by a clinician who could act on this result. A solution was suggested that would change the process and ensure that any abnormal blood result got actioned appropriately.

9.83   In 2022 (21 months after the event) an external review of deaths was undertaken and included this and other deaths in similar services. This was an independent review carried out by clinicians from outside the Trust. It was undertaken after a legal representative of the families involved wrote to the Chief Executive of NHS England requesting this review and the Trust agreed. This report was shared with the Trust Board members, commissioners, NHS England, the coroner, and the families of others who had died using similar services.

9.84   This was a tabletop exercise, and the purpose of the review was to provide assurance that the original investigation had followed the correct process, had been thorough and complete. and had developed comprehensive recommendations that provided further learning with reference to risk assessment, observations and monitoring of observations.

9.85   When we spoke to the external investigation team, they did not recall being made explicitly aware of the falsification of documentation. They described tight terms of reference that allowed them to look at the process of reviews but nothing outside. They had access to the previous reviews and no other material that they can remember. The review did not find any areas of concern with the Trust's investigations.

9.86   In 2022 (two years after the incident) a coroner's inquest took place. Matters of concern were raised and a Regulation 28 was issued. The coroner recorded a verdict of neglect, in that there was a failure to communicate the findings of blood tests analysed that showed a life-threatening abnormality. The matters of concern raised were about the actions the Trust had taken with regard to observations and about the levels of inexperience of staff working on the unit.

9.87   Evidence given at the coroner's court described the procedure for abnormal blood results management. This evidence suggests that the concerns raised by senior clinicians after a safety alert had been communicated in the previous year had not been actioned.

9.88   The Trust was required to respond to matters of concern raised in a Regulation 28 report within 56 days of receiving them. GMMH has a process for managing Regulation 28 – Prevention of Future Deaths reports. When such a regulation is received, the leads from the care group/service involved meet with the Trust's executive panel where an appropriate and proportionate response is agreed, and a response written to the coroner. Any actions arising are addressed via an action plan which will be undertaken and monitored by local leads. Learning resulting from Regulation 28 reports is shared more widely in the Trust through learning events, seven-minute briefings, and inclusion in a patient safety newsletter. The GMMH inquest team monitor actions arising and report on a monthly basis to both post-incident review meetings and the Quality Improvement Committee.

9.89   In 2022 the Trust held a workshop on service user observations in inpatient areas; the output of this event recognised need for more carer involvement.

9.90   After this workshop in 2022, the Trust responded to the coroner's Regulation 28: it responded with actions for two out of three of the matters for concern raised. It had no action against the issue raised about the inexperience of staff on the unit and described the current processes in managing staffing need within this service. This is despite the earlier disciplinary reviews raising concerns about the skills mix on the ward. It responded to the matters of concern about observations with actions to complete a thematic review, to review policy and practice and determine training needs, and a plan to test out within a specific area of the Trust before rolling out across the Trust.

Subsequent actions and monitoring after the Trust response to the Regulation 28 report

9.91   In March 2023 there was a workshop described as an initial engagement session to scope out practice in the Trust. This workshop identified the need for more involvement from unregistered staff and those with lived experience. A subsequent workshop took place on 19 April 2023.

9.92   In April 2023 the Quality Improvement Committee received an action plan appended to a relevant paper stating:

"*The actions arising from the Regulation 28 completed in January 2023 was for observation audits to be reviewed and any themes identified to address concerns raised by the coroner. This piece of work is currently being led by the associate directors of quality in specialist and Adult Forensic Services and will drive the review of observations policy and practice trust wide.*"

9.93   In May 2023 there was a meeting of the Therapeutic Observation Group (established sometime in 2023). This group was working to harmonise policies between the Trust and another recently acquired organisation (Wigan services) and to change the focus of observations practice. It described this work leading to a training package, competency framework and assessment and audit process. This makes no reference to the audits that were said to have been completed by January 2023, nor any themes that might have been identified.

9.94   In July 2023 the Quality Improvement Committee - Learning from Deaths Report, described actions taken in response to this Regulation 28. This was described as Service User Observation within inpatient areas. A description of actions taken included: a workshop, a thorough review of the observation policy and practice, considering best practice standards and guidance, setting out a legal and best practice framework and undertaking a training needs analysis and agreeing a competency assessment framework. After this work was completed, there were plans for a pilot to be undertaken within a division and then for this work to be rolled out across the Trust. This makes no reference to the audits that were said to have been completed by January 2023, nor any themes that might have already been identified.

9.95   In September 2023 (35 months after the event) our review team requested and received two documents describing the procedure to manage abnormal blood results. These were undated and so we do not know when they came into action. However, in light of the evidence given to the coroner, it must be assumed that this was between the coroner's court (November 2022) and the date of request (31 August 2023). Both documents describe the change in action as described by senior clinicians in November 2021 after a safety alert issued that same month, i.e., that the form must include information that ensures a clinician with authority to act receives any abnormal blood results.

9.96   The current observation policy available on the GMMH website does not have evidence of any updates associated with these actions and has a review date of June 2023. We were advised by the Trust that regular observation audits were taking place in CAMHS. We requested the audits from July 2023 and received those from one week of July (week commencing 27 July 2023) and the audits from weeks commencing 3, 10, 17 and 31 August. Initially, the Trust told us that the audits were not available for the whole of July as they had been sent to a member of staff who was not in work. The Trust told us they were exploring whether they could access the audits another way.

9.97   We then asked for the month of June as we wanted to review a complete month. Following this request, we were told that the missing audits for July had not been completed and that "*you were misinformed.*" We asked the Trust to send us the process for completing the audit and what dates

the audits were available for us to review. We were then told that "*It has come to our attention there was no formal system and process in the form of governance and the application of this audit at ward level. Furthermore, Quality Risk and Assurance Group had been advised that this audit had continued to be implemented.*"

9.98   The dates that the audit was available for showed that it was not always being completed. In 2021, the audit was completed 17 times out of a possible 28 (61%); in 2022 it was completed 25 times out of 52 (48%); and in 2023 it was completed 9 times out of 36 (25%).

9.99   We reviewed the audits that were supplied from July and August. These were described on the form as an 'Observation Ward Managers Spot Check Assurance Audit'. This appeared to be a weekly audit, specifically looking at whether:

- level 3 observations and planning had been completed;

- enhanced observations had been completed;

- an MDT review had taken place;

- seclusions procedure had been followed; and

- a spot check to ask staff if they understood what they were checking for in relation to observations and how to raise concerns. These would not pick up falsification of records.

Conclusion

9.100 This review concentrated on how the Trust's systems and processes functioned in response to the opportunity to learn from the death of an individual using their inpatient services. In particular, how improvements could be made about the management of abnormal blood test results in-house and the management of observations.

9.101 It is not clear what happened between the tragic event and November 2021, when a safety alert was issued after the serious incident review in October 2021. Concerns were immediately raised about the safety alert, by senior clinicians working within these services, regarding the content of that alert and its impact on the problem it was designed to solve. Evidence suggests that actions to resolve these concerns were not taken for many months later. The documentation received by the review team describes these issues of concern being addressed, but no date as to when this happened. There seems to have been a missed opportunity for the clinicians working on the unit to be involved in workable remediation of the safety issues identified.

9.102 The actions taken around observations are difficult to follow. An initial management review was taken promptly, but a recommendation to look for similar poor practice elsewhere in the Trust was not taken forward. This review did make recommendations for a change in practice on the unit and some new assurance processes were introduced. There were no other changes. The serious incident review adds no other substantial recommendation for change.

9.103 The improvements suggested from then on lack continuity and clarity and do not address the initial finding that a number of staff who were deemed competent to carry out observations on the unit were not always doing so in the correct manner and were on occasions falsifying records. There was a missed opportunity to be curious as to why staff were behaving in this way. It is noteworthy that there were issues with observations in other similar cases and within the issues identified at Edenfield. The improvement plans appear to change and lack clarity. The focus is on changing and developing new policy and practice and training. The Trust reviewed and ratified their Therapeutic Engagement and Observations Policy in September 2023. However, it is noteworthy that it doesn't address the original problem. There was no issue with the policy and the Trust was able to demonstrate that a number of staff working on that ward understood the policy and its implementation, but for reasons that are still not fully understood, they failed to follow its guidance.

Background to the improvement plan

9.104 The level and type of oversight which NHS trusts and ICBs will have is determined by the NHS System Oversight Framework. Organisations are placed in one of four 'segments' with four being the lowest performing, and defined as 'Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support' (NHS England).

9.105 In November 2022, NHS England placed the Trust in segment 4, and it entered the Recovery Support Programme, which is designed to ensure that trusts have the intensive support needed to make improvements. The Trust has since produced an improvement plan which sets out how it will make the changes needed to exit segment 4, improve the quality of care, and start to move forward from what was exposed through Panorama.

Improvement plan: structure and governance

9.106 The improvement plan is divided into five workstreams with 139 actions in total. Each workstream has component actions and an executive sponsor. These are:

- *Patient safety*: This has 67 actions and its executive sponsor is the Chief Nurse.

- *Clinical strategy and professional standards*: This has 15 actions and its executive sponsor is the Medical Director.

- *An empowered and thriving workforce:* This has 23 actions and its executive sponsor is the Director of HR.

- *An open and listening organisation*: This has eight actions and its executive sponsor is the Director of HR.

- *Well governed and well led Trust*: This has 26 actions and its executive sponsor is the Deputy CEO.

9.107 The plan is clearly ambitious and broad ranging in its focus. In understanding the scale of change required, many people we spoke with felt that the plan is unwieldy, and it is difficult to understand what the organisation's key change priorities are. A notable comment in this area was:

"*We would have been better clearly stating what the four or five things we really want to achieve are, and putting our efforts behind these.*"

9.108 Many people we spoke to, both internally and externally, expressed a concern that the scale of what the Trust is trying to deliver could be unachievable, especially with its current leadership constraints. Four of the five workstreams now have a substantive executive lead and one workstream has an interim lead.

9.109 The NHS England-led System Improvement Board has overseen the progress of the improvement plan to date. The Trust's internal governance and oversight of the plan are still being agreed, and it is important that this is clear so that the Board can be assured of delivery and any risks. The Trust has told us that the Board has received a report which outlines the governance structure of the improvement plan through five workstreams reporting to an Improvement Steering Group. The Board also receives regular progress updates, including on risks. We have not reviewed these documents. The Trust should also consider its arrangements for having separate processes for monitoring compliance with CQC notices, as this adds further complexity to its improvement oversight.

Development of the improvement plan

9.110 The organisation consulted widely in the development of the plan and many stakeholders provided views on what should be included. We heard that significant resource and effort were put into ensuring that people were able to contribute to its content.

9.111   Nonetheless, we saw and heard concerns that the importance of working collaboratively with patients, carers and all partners has not been sufficiently reflected in the content of the plan. It is important that the Trust addresses this in light of the findings of this review regarding the strength of the patient's voice in the organisation. This is, in our view, a cultural change which needs to take place.

9.112   The Directors of Adult Social Services (DASS) wrote to the CEO and Chair on 18 April 2023 to express their disappointment in the improvement plan around the lack of acknowledgement of the partnership arrangements surrounding social care.

"*As a DASS group we have raised significant concerns on an ongoing basis regarding assurance and the safe delivery of services mainly in the integrated services within the community. As DASS we are concerned that the new duties for CQC inspection for Local authorities of Care Act duties cannot adequately be demonstrated within the integrated partnership arrangements for community Mental Health services, this risk needs to be addressed collectively.*"

9.113   The letter continued to outline areas where the improvement plan needed strengthening.

9.114   The CQC also wrote to the Trust to share concerns about the size and complexity of the improvement plan and the capacity of the Trust to deliver it.

9.115   Patient groups also shared their disappointment about the lack of patient involvement in the plan.

Content

9.116   The breadth of scope of the improvement plan is commendable and suggests the Trust's ambition for change. The plan presents a real opportunity for the new executive team to reset the Trust and signal clearly that they want to do something different. To some extent, its content has been driven by exiting System Oversight Framework segment 4 and this has put an emphasis on short-term and more transactional matters. These are essential to address, including some of the hugely important safety measures such as ligature management. This has led, in our view, to a disproportionate focus on processes and inputs, with insufficient weight given to the cultural work needed to embed sustainable improvements for patients and staff. Without this cultural work, there is a risk that actions taken will not embed, as staff and managers will not have sufficiently 'bought into' the need to do things differently in the long term. We set out the key areas for development in the improvement plan below.

- **Success measures** – These have been defined in most cases, but not all, with some items listed in this column being outputs (such as policy changes) rather than outcomes which will be felt by patients. Those overseeing the plan should consistently ask themselves "What improvement are we trying to achieve? What changes can we make that might result in this improvement? How will we know that this change will result in this improvement?" (NHS England and Improvement,2022). For actions linked to seclusion and long-term segregation, for example, there is currently no intention to measure patient experience linked to this restrictive practice. Changing seclusion practice is a complex problem and changing a policy on its own has not been shown to lead to sustained change of practice[33].

- **Realistic goals and timelines** – As of late August 2023, 24 of the 139 identified actions are overdue for completion. This is likely reflective of the scale of the plan and a need to rationalise and prioritise its ambitions. For example, the plan has an action for working with NHS Professionals to ensure all staff hired by them are PMVA trained by March 2023. This date has long since passed and the action remains open.

- **Impact** – Some actions are marked as completed but not yet tested: one of these is the Trust's new Seclusion and Long-Term Segregation policy. Policies and processes are an important part

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[33] In the national Mental Health Safety Improvement Programme (Health Innovation Network, 2022) (42) to reduce restrictive practice, the biggest finding was that interventions that improve the relationships between staff and patients made the biggest difference (changing the policy was not associated on its own with any improvement). In order to make an improvement in seclusion there needs to be clarity around what the Trust are trying to achieve. If the aim, as it should be, is to reduce episodes of seclusion/segregation, then there needs to a statement of how much by and when.

of delivering safe care; it is essential that the plan and actions recognise that policies are 'work as imagined' and recognise the importance of training, skills, competence and culture in effective and safe care. There is a risk that if actions are marked as completed before their impact is understood (such as staff awareness and training on the new policy and implementation), they lose focus and oversight before changes have been made. In the case of seclusion, this is particularly important given what was exposed by the BBC.

- **Level of detail and interdependencies** – There are examples in the plan where the existing problem may not have been fully explored and understood before defining the action required. For example, an action has been recorded relating to the training of staff in PMVA. We have heard from many groups of staff across the Trust that temporary staff are reluctant to get involved in restraint, as in case of injury, they do not get sick pay and therefore will lose their livelihood. The action to address the shortfall of PMVA-trained staff does not identify what a safe number is. This action illustrates the need for the problem to be understood more fully, with the support of direct care staff, to identify the right action to address the issue.

- **Extent to which issues have been considered systemic rather than localised** – There are examples of the improvement plan treating issues in a very localised way. For example, the racism concerns raised at Park House are not explored across the Trust but are worded as a 'Park House' matter in the improvement plan, even though the Trust has acknowledged publicly that this is an issue across the organisation. There is no reference in the plan to how patients are affected by racism in the organisation. There is no mention or exploration of the impact of racism on patients.

9.117   In summary, the plan should ensure that it is prioritised, realistic, fully thought through (with the right expertise), and with appropriate outcome measures to assess its impact. Its core focus must be on delivering excellent care to patients; improved relationships with regulators, and consequently less regulatory scrutiny, should be a by-product of this and not the primary goal. This includes ensuring a balanced approach between the scale of the improvements required and setting out a realistic timescale for implementing identified actions with the support of their system partners.

Conclusion

9.118   It is critical that the Trust is able to evidence learning and improvements when things go wrong. This is particularly important in the case studies we have looked at, where patients have died, and families are grieving. Families who were impacted by BBC Panorama are also experiencing their own trauma. Our analysis found that while the Trust is increasingly seeking to learn and make improvements when things go wrong, there remain long-standing cultural issues, as well as weaknesses in its governance processes which are stopping this from happening effectively. We make further commentary about these areas in Chapter 6.

9.119   Changing culture takes time and commitment, and it is important that this is fully understood by the Trust and its partners. The focus of the new Trust leadership should be on creating a learning culture, in which staff feel safe in speaking up and improving their services. We note that the Trust has made a considerable investment in developing its capability in a systematic approach to quality improvement. There is an opportunity to continue to build the governance and improvement infrastructure supporting this approach to enable delivery of some of the quality improvements that the Trust needs to make.

9.120   Alongside this, the structures and processes put in place to respond to adverse events need to enable leaders to have a clear understanding of what has happened, giving them the information they need to measure improvements and a culture in which they are able to report this safely.

9.121   In this chapter we have described how the organisation seeks to learn and improve. In the next chapter we describe what we found when we looked at other areas of the Trust.

Chapter 10 Elsewhere in the organisation

Introduction

10.1   The scope of our work included forming an opinion on whether what was identified at Edenfield could be happening elsewhere in the Trust. To do this, we assessed the main contributory factors which enabled what happened at Edenfield to unfold. We did this by reviewing the BBC journalist's dossier of evidence ('*Annex A*'), reviewing key documents relating to Edenfield, and visiting the site to understand the care environment and its challenges for ourselves.

10.2   The main conditions we identified as contributing to the failings at Edenfield were:

- Patients, their families and/or carers not being listened to and taken seriously

- A weak and fragmented clinical voice

- Unsafe levels of staffing and high use of temporary staff, leading to inadequate skills, knowledge and experience required to care for their patients

- A poor physical environment

- Poor culture, including a lack of psychological safety and low morale, including unsupportive leadership behaviours, unsound HR practices including perceived unfair recruitment and promotion and a lack of transparency about formal investigations

- Conditions leading staff to not adhere to clinical policies such as record keeping and observations

- Some staff described being treated unfairly because of a protected characteristic

- Some staff reported not being supported to acquire the skills, training and knowledge to carry out their role

- Poor governance practices

Method

10.3   We then looked for signs that these issues might be presenting elsewhere in the organisation. We called this a 'sample test'. It is important to note that we were constrained in the time we had available to apply this test, and as such we have had to limit ourselves to identifying any major risks presenting in each area. We believe there is risk in other services which should be of concern to the Board, and more detailed responsive reviews of certain services should be commissioned independently of this work.

10.4   In order to identify which areas we wanted to sample test:

- we looked for potential 'hotspots' which were evident from key documents such as the National Staff Survey, the Safe Staffing report and CQC activity reports;

- we reviewed patient safety incident investigation reports;

- we spoke with staff working in central departments; and

- we spoke to external stakeholders to seek their views.

This resulted in us visiting the following places:

1.   **Park House** which provides a number of services including acute care for adults of working age, wards for older people with mental health needs and a long stay rehabilitation ward.

2.   **Woodlands Hospital** which provides care for older people with mental health needs.

3. **Junction 17 and the Gardener Unit**, which provide CAMHS in both acute and a medium secure setting.

10.5 Our review involved us visiting each service to speak to staff and patients, and to form our own view of the care setting.

Conclusion

10.6 It was clear from this part of our work that these services face some significant challenges, many of which are reflective of those we found at Edenfield and could potentially lead to similar outcomes for patients. In some of these services we found indicators of closed culture environments. Staffing is low at all of these sites; at some sites we found low morale and we found evidence of staff being discriminated against based on race and ethnicity. We also found that there had been improvements in some areas, including changes to environments, some staff feeling more able to speak up, the clinical voice becoming stronger, and more visible, empowered leadership.

10.7 In this part of the review, we have not been able to fully assess the scale of the risks in these services, nor have we reviewed all the services which we identified as potential areas of concern. Had we had more time, we would have also liked to have visited:

- community mental health teams in Manchester;

- prison health services; and

- Laureate House in South Manchester which has acute wards, a psychiatric intensive care and a ward for older people.

10.8 The impact of the challenges faced by services named in this chapter needs to be understood more fully to determine the effect on quality and safety. There needs to be a second stage review which can more fully explore services potentially in distress at GMMH to understand the current state of safety, any immediate actions required, and longer-term actions to ensure that the culture and clinical model of these areas are set up to provide high-quality care.

Findings

10.9 In this section, we describe what we found when we visited the sites mentioned above.

Park House
Service overview
Park House is a 142-bed site, providing care for: - working age adults in acute wards - those in psychiatric intensive care - older people - people needing rehabilitation. It is located in Crumpsall, North Manchester. Management of the site transferred to GMMH services in January 2017. CQC rate mental health services by service type and not location, therefore the ratings here are for all wards which provide the service, not just Park House. Current CQC ratings are as follows: - Acute wards for adults of working age and psychiatric intensive care units: rated inadequate overall (July 2023) - Wards for older people with mental health problems: rated requires improvement overall. (February 2023)

- Long stay or rehabilitation mental health wards for working age adults: rated good overall. (February 2018)

Why we visited this service

Culture

For staff in North Manchester, 96 of 104 questions on the 2022 NHS staff survey had responses which were worse than the Trust average, which itself benchmarked very poorly compared to other mental health trusts in England.

Concerns had been raised by some staff that they were not being treated fairly because of their race. The Trust had commissioned an internal review into this.

CQC concerns

In 2022, the CQC had issued warning notices relating to:

- poor management of fire risks, including patients smoking on wards and staff training;
- ligature risks not being effectively managed.

A warning notice is issued when there are significant improvements needed to the quality of care. In April 2023, the CQC issued a further warning notice as the Trust had not made progress against the requirements of the July 2022 warning notice. This suggested a lack of learning and recognition of the changes required.

Physical environment

The building is old with maintenance issues, which could have been impacting on patient safety and quality of care. It has what is known as dormitory accommodation, which is where patients share their sleeping space. This has inherent issues and risks to personal safety, privacy and dignity, disturbed sleep and can present problems such as a risk of theft of personal belongings.

Staffing

There was a high vacancy rate among nursing and allied health professionals, and high use of temporary staff.

Historical concerns

In December 2020, the CQC visited Elm Ward at Park House and raised concerns regarding whether some of the wards were large enough for the number of patients being cared for in them.

In September 2021, the CQC raised various concerns regarding the environment and cleanliness of Poplar Ward. It also identified concerns regarding staff having access to up-to-date ligature risk assessments to help them reduce the risks for patients.

The Trust is aware that Park House is an old building with a number of issues which impact the safety and quality of care. The Trust's Estate Strategy 2022–2027 sets out that all but one of the Trust's high priority estates risks have been identified and located at Park House. It also states that "*it is considered unfeasible to address these in the interim period*" as a new unit has been commissioned and should be ready for patients in 2024. These risks were to be mitigated locally.

What we heard and saw

We assessed Park House against the issues we identified at the Edenfield Centre, described in the method statement above, and found that:

- The clinical voice was becoming stronger. An example of this clinical leadership was the service was moving to a system where the people with the most clinical need and greatest risk were admitted first rather than those who were impacting acute hospital Emergency Department targets.
- The medical team had a full consultant complement (including a long-term locum). They had implemented some rules about civility and worked together cohesively.

- Staff had felt able to raise their concerns with a colleague about their experience of unfair treatment because of their ethnicity.
- Some improvements had been made in response to quality concerns, such as reduction in bed numbers on the largest ward and the use of surge beds had stopped.
- Patients now had lockable storage to keep their possessions safe.
- Patient feedback was generally positive, and we observed positive interactions between staff and patients.

We also heard:

Discrimination: Some staff we spoke with told us that they experienced racial abuse from patients, and we were given examples of physical violence. This was confirmed by the findings of the internal review about the concerns raised by staff. Park House Responsive Review Report went to Board in July 2023. A media statement by the Chair of the Trust apologised and shared the findings:

The review found that the structures and culture at Park House have meant that:

- Ethnically diverse staff who engaged in discussions felt they have experienced fewer opportunities in relation to career progression, resulting in a lack of representation in senior leadership roles.
- They felt unsafe due to racial abuse from patients and that abuse has not been dealt with effectively resulting in loss of faith in the system.
- They experienced disproportionate disciplinary action at higher rates compared to their white counterparts.
- They felt unable to raise concerns for fear of no action being taken or fear of retribution.
- They felt generally excluded and unwelcome which has led to a perception of divisions between wards.

There was a pledge to address the issues identified, which included:

- the establishment of an Anti-Racism Steering Group;
- co-production of an anti-racism action plan that will set out the actions required to roll out the Patient Carers Race Equity Framework (PCREF).

Staffing: Some people told us that the lack of staff impacted the quality of care they were able to deliver. Staff were often asked to move to other wards which meant they did not know their patients as well as they might otherwise. There was a high use of temporary staff, who are not all trained in PMVA. This means that there are fewer staff available to safely manage patients when they need to be restrained, and this creates extra pressure on the staff who are trained in PMVA.

There were not enough psychologists or occupational therapists, which meant that patients could not easily access the required support for their recovery, and the multidisciplinary teams did not always include input from all professional groups.

Culture: Some staff told us that they felt that operational leaders still have the most powerful voice in the senior leadership team, and that they did not have sufficient control locally to improve the quality of care. For example, staff were told to admit patients even if they had said it was unsafe. Some staff told us they felt bullied when they raised challenges in Trust operational meetings.

Some staff did not feel empowered to make the changes needed to improve the quality of care. Some staff told us that after raising concerns about racial abuse, they had not been involved in the review, and the action plan had been developed centrally without input from those who were experiencing the issue. In the 2022 NHS Staff Survey 38.6% of staff felt involved in changes that affect their work. This was the fourth lowest score in the Trust's 24 divisions.

We were told that a small number of people had raised issues with the FTSU guardian and only one had received a response. Mostly staff we spoke with felt able to raise concerns, and that they would be listened to.

The NHS Staff Survey 2022 data was divided into 24 divisions. Park House results were in Manchester North Services which included the whole division, not just inpatient staff. Manchester North had the third lowest score of the 24 divisions with 14.5% of staff feeling there were sufficient staff to do their job (only Manchester South and Adult Forensic Services scored lower). This score was significantly lower than the whole Trust result of 24.6%.

Environment:

In terms of the environment:

- Patients told us that being cared for in dormitories impacted their recovery as there was a lack of privacy. One patient with autism said they found it very stressful being in a shared space. Caring for highly distressed patients in dormitory accommodation where they do not have their own safe space is very difficult for both the patient and staff.

- Staff described challenges with the gender mix of staff on wards which meant that they were not always able to provide gender-sensitive care or to do so they had to not follow Trust policy and best practice. One example was that there was a female patient being cared for in seclusion and female staff were required to provide observations.[34] As there was only one female member of staff on duty, they had to provide continuous observations for seven hours of their shift. This is not in line with Trust policy and NICE guideline [NG10] (NICE, 2015) which states that staff should not carry out observations for more than two hours at a time and should have regular breaks.

- Patients openly smoked in the gardens and, when we visited the site in July, nearly all acute wards had many cigarette ends in them, as did the garden. Patients told us that some people smoked in the wards.

- Senior clinicians' and administrators' offices sometimes flooded.

- Wards all had different fittings and fixtures which makes it more difficult for staff to recognise ligature risks when they move wards.

Woodlands Hospital

Service overview

Woodlands Hospital is a 50-bed unit providing care for older people with mental health needs. It is located in Little Hulton, Salford. Its CQC rating falls under that of 'Wards for older people with mental health problems'. This is rated requires improvement overall (February 2023).

Why we visited this service

Staffing

The service was short-staffed, with nurses covering more than one ward reported by the CQC in February 2023. There was a lack of medical staff.

Enforcement action

The CQC had issued a s29A Warning Notice in November 2022, specifically to this hospital. This related to staffing levels and medicines management. They had also identified issues with blanket restrictions (MHA Code of Practice, 2015) and care planning for patients.

Environment

There were concerns around poorly maintained and damp estate. Ligature risks had not been identified and acted on appropriately.

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[34] Observation is a minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a patient to ensure the patient's safety and the safety of others.

Historical concerns

There was a CQC inspection of the hospital in November 2022. This found that there were not enough nursing and medical staff who knew the patients and had received basic training to keep people safe.

Staff turnover and sickness rates were high. There had been frequent occasions where one nurse was allocated to more than one ward and registered nurse associates allocated as the nurse in charge; these roles should always work under the direct supervision of a registered nurse.

What we heard and saw

We assessed Woodlands Hospital against the issues we identified at the Edenfield Centre and found that:

- Nursing staff were passionate about their patients and keen to do their best for them. They were proud that feedback had been more positive following a recent CQC revisit. It was clear that staff supported each other.

- The nurse staffing picture had improved somewhat. The introduction of a 'floater' qualified nurse meant that even if someone was off sick there, would still be enough qualified staff.

- There had been improvements made to the environment and the hospital looked clean and well maintained.

- Staff told us that the new leadership team was visible and supportive. It was commented on positively that they sat and had lunch with staff. Staff reported as feeling more listened to.

We were also told:

- The service had been particularly impacted by the pandemic, and sadly some of its patients died from COVID-19. Staff described that other areas in the Trust had been supportive during the pandemic, but they did not feel that the impact of the pandemic on the unit, and their hard work, had been acknowledged by the Board and senior leaders at the time.

- While staffing had improved to some extent, there was still high usage of temporary staff. Historically, staff told us that the service had regularly not had enough staff, with nurses often holding keys for more than one ward. This was usually at night when there was no medical cover on site. Staff told us that when they refused to hold two sets of keys, they had been made to feel selfish. One example was shared when there had been one qualified nurse for all three wards.

- Medical staffing was precarious with only one substantive consultant. The Trust had identified this as a risk and were managing it through the business continuity process. Staff described it as challenging with the number of temporary medical staff impacting on patients and them.

- Since the CQC inspection in November 2022, staffing has improved, but there remained a reliance on temporary staff who did not know the patients as well as permanent staff. Before the CQC inspection, staff had regularly had to work through a shift without breaks, they were often moved between wards and there had been lots of changes at ward manager level which had been destabilising for staff.

- There had been a lack of senior leadership visibility, which was perceived as having become worse since the pandemic. Staff had not felt listened to previously about their concerns regarding staffing and felt that managers only became visible 'when something goes wrong'. Staff did not know who senior managers in the Trust were.

- When things went wrong, such as safety incidents, there had been a lack of debrief, reflection and learning. This was now changing.

Inpatient CAMHS: Junction 17 and the Gardener Unit

Service overview

Inpatient child and mental health services are delivered through two units in Prestwich. Junction 17 is a 15-bed unit providing specialist mental health care for young people aged 13 to 17. The Gardener Unit provides care to children and young people in a forensic setting and is one of only four nationally commissioned forensic services for children and young people. At the time of our visit, there was also a five-bed ward for people aged 18 to 25 (Griffin Ward) which has since been closed.

The CQC rating for child and adolescent mental health wards is currently Good overall, with the caring domain rated as Outstanding.

Why we visited this service

Staff turnover in CAMHS overall is exceptionally high. In the National Staff Survey results for 2022, 86 of 104 questions were below the Trust average, which itself benchmarked very poorly compared to other mental health trusts in England. (See Chapter 6 Culture, about historical whistleblowing relating to this service.)

The CAMHS service had been in the same care group (Specialist Services) as Edenfield, and therefore had come under the responsibility of the same senior leadership team.

A number of people had raised concerns about the service via the FTSUG.

Historical concerns

There had been three deaths of young people between 2020 and 2021.

What we heard and saw

We assessed these units against the issues we identified at the Edenfield Centre and found that:

- Staff were passionate about providing good quality care to their patients.

- Staff delivering care felt well supported by local ward leaders.

- The senior leaders had recognised the high turnover of staff and were working to improve retention.

Some groups of staff reported that the multidisciplinary teams worked effectively together and described a supportive cohesive leadership team.

We were also told:

Staffing: In the NHS Staff Survey 2022, only 19.8% staff who worked in CAMHS (this includes inpatient and community staff) felt there were enough staff to do their job, compared with the Trust average of 24.6%.

People told us that there were not sufficient staff, especially at night. There was a recognition of a skills gap, notably with insufficiently experienced nurses. This led to challenges about supporting newly qualified staff, including how they should provide care in the least restrictive way. We heard from some junior staff that there was a lack of clarity as to how best to support young people who were tying ligatures.

Understaffing was leading to there being insufficient time to build therapeutic relationships with young people. It also means an over-reliance on temporary staff who:

- do not know the patients well;

- are not all trained in PMVA and so cannot restrain patients. This places a further pressure on the permanent staff who are trained in PMVA.

Support: Lack of staffing meant that the Preceptorship Framework could not always be followed, and examples were shared where learners had struggled to progress with their preceptorship. Nurses who were on preceptorship were not sufficiently supported and preceptees often worked

alone without another qualified nurse. This is not compliant with Trust policy and the Multi-Professional Preceptorship policy.

Culture: In the National Staff Survey results in 2022:

- 36.8% of CAMHS staff felt relationships at work were unstrained compared with a Trust score of 49.6%.

- 37.9% of CAMHS staff felt that staff involved in an error/near miss/incident were treated fairly compared to a Trust score of 47.7%.

- 64.6% of CAMHS staff would feel secure raising concerns about unsafe clinical practice compared to a Trust score of 69.7%.

The culture of the service was described as hierarchical by more junior staff, who felt criticised particularly for how they managed restrictive practice, without being given appropriate support. Staff described a fear of having their judgements undermined and talked about in safety huddles. A key comment in this area was "*Those who are doing the doing don't feel safe*". Staff described that those above deputy ward manager level felt very separate from the service.

Cultural issues were leading to burnout and resignations. Some staff did not feel listened to and had chosen to leave the service. We were told that some of this was due to staff feeling unsafe in their working environment. Some told us that they had taken their concerns to FTSU but that nothing had changed.

We heard about a number of concerns that impacted on consultant recruitment and retention across a range of areas. These included operational management overruling a clinical safety decision, and external influence attempting to overrule consultant decision-making.

While we visited inpatient CAMHS services, concerns were also raised with the review team about the community CAMHS service, where similar issues were presenting. We were told of a culture of:

- patients and staff not being listened to and patient safety concerns being disregarded

- long waiting lists

- people being discriminated against because of protected characteristics

- an inability to challenge management

- incivility from some senior managers

- failure to manage and resolve consultant group dysfunction

- 'in' groups and cliques

- a lack of senior level support.

10.10 This chapter has described what we found when we looked at other areas of the Trust. Next, we will look at how the other organisations in the system responded.

Chapter 11 System oversight

Changes in healthcare systems

11.1 Partnership working has seen an increasing focus in NHS policy in recent years, as described in previous chapters of this report. This is partly in recognition of the fact that NHS providers do not (and cannot) work effectively in isolation.

11.2 The last three years have seen enormous challenges and changes across every part of the health and care system which have altered how care is commissioned and planned. These changes were happening alongside a global pandemic which health and social care systems were at the forefront of responding to.

Impact of the Health and Care Act 2022

11.3 Until July 2022, clinical commissioning groups (CCGs) commissioned health services in set geographical locations and monitored the delivery of those services. To promote collaborative working among health and social care organisations, the Health and Care Act 2022 introduced integrated care systems (ICSs). These are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, coordinate and commission health and care services.

11.4 ICSs operate across larger geographical footprints than CCGs did previously. This means that their oversight role of providers has effectively grown much larger. Until April 2022, there was a lead CCG identified for monitoring quality of care at GMMH, except in Health and Justice where NHS England Specialised Commissioning had this role. Meetings were held every quarter. With the move to ICS', the governance processes changed, and we heard that some of these are still in their maturing stages.

11.5 The Health and Care Act 2022 also brought significant changes to the structure of national bodies charged with oversight and support to NHS trusts. Of note, NHS Improvement, Health Education England, NHSX and NHS Digital were incorporated into NHS England, who took on responsibility for workforce planning, training and development, setting standards for use of technology in the NHS, and providing data. These mergers created significant change within these bodies, and also led to reductions in staff across national and regional NHS England teams.

Local provider collaboratives

11.6 At the same time, the ways in which specialised services[35] are overseen in England has changed, through the formation of provider collaboratives. This has involved the transfer of responsibilities from NHS England Specialised Commissioning to local provider collaboratives[36] (LPCs) to commission and oversee specialist services.

11.7 GMMH is the lead provider of the LPC for adult secure services in Greater Manchester. This means that this is the organisation which is accountable to NHS England for the commissioning and oversight of specialist services. This includes Adult Forensic Services for Greater Manchester.

11.8 It is important to note that these arrangements represent a shift in how services have historically been commissioned in the NHS, in which there was traditionally a clear distinction between the commissioner (the planner and buyer of services) and the provider (being the organisation providing care to patients). LPCs nationally are still developing the governance structures and processes to manage this shift.

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[35] Specialised services support people with a range of rare and complex conditions.
https://www.england.nhs.uk/commissioning/spec-services/

[36] NHS-led provider collaboratives are local partnerships of organisations which provide specialised mental health services, and they are being established across England.

11.9 Key staff in the Trust and system partners told us that the oversight and governance of services, internally within GMMH and also by the system, were reduced during the pandemic. This is not specific to GMMH, and nationally, a whole range of oversight meetings were stood down during the pandemic so that trusts could focus as much of their resource as possible on providing care. However, some interviewees also told us that the combination of all the structural changes outlined above, alongside the pandemic, has meant that system oversight has lost its former rigour.

11.10 Some partners described how the local and national system's approach to recovery from the pandemic had been mostly focused on acute care, with central targets set for elective surgery, Emergency Department and ambulance waiting times, and cancer referrals for example, but with no equivalent focus on mental health services, other than the Long Term Plan and the continuation of the mental health investment standard. Some system partners we spoke to reflected on the time it has taken to re-establish robust oversight of mental health providers. We were told, for example, that commissioners had expressed concerns regarding the Trust's high levels of open serious incident action plans. While this was acknowledged by its commissioners, it is unclear what action is being taken to improve this.

11.11 The pandemic led to in-person visits being stopped by a number of stakeholders including NHS England Specialised Commissioning case managers, Healthwatch[37] and CQC Mental Health Act reviewers. More generally, the CQC stopped routine visits to the NHS at the start of the pandemic and then re-started these on a risk basis, with those rated higher risk being inspected again first.

11.12 When restrictions eased following the pandemic, we heard of various stakeholders who were held at reception and unable to enter the unit. This included families and carers of patients, the Trust's Quality team staff and case managers. Healthwatch told us that they received varying degrees of engagement from the Trust, depending on which borough they were working with.

System mapping

11.13 GMMH is overseen and regulated by various bodies. When we talk about "the system" in this chapter, we are generally referring to all or some of the bodies below. We summarise the role of each of these in overseeing the quality of care provided by trusts below.

NHS England Regional Team	NHS England has seven regional teams who support local systems. GMMH and Edenfield are under the North West Regional team.
	The NHS England website states these teams "*are responsible for the quality, financial and operational performance of all NHS organisations in their region… They also support the identity and development of integrated care systems.*"
NHS England Specialised Commissioning	Most NHS services are now commissioned by ICBs, although NHS England remains the accountable commissioner for very specialised services. "*Specialised services are accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. They are provided in relatively few hospitals.*" (*NHS England*[38])
Care Quality Commission	The CQC is the "*independent regulator of health and social care in England*" (CQC[39])
Integrated care board	The majority of NHS England's budget is allocated to ICBs which commission services for their populations. ICBs have taken over most commissioning

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[37] Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

[38] https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/our-services/specialised-commissioning/

[39] https://www.cqc.org.uk/about-us/our-purpose-role/who-we-are

	responsibilities previously held by CCGs. They are accountable to NHS England for how they spend their funding and the performance of the system.
Provider collaborative	An NHS-led provider collaborative is a group of specialised mental health services who have agreed to work together to improve the care pathway for their local population.[40] (NHS Data Dictionary). Provider collaboratives have a lead provider. This is "*a single trust [which] takes the responsibility, and contract, to deliver a set of services on behalf of the provider collaborative*[41]". (Kings Fund 2023). As stated above, this blurring of role between provider and commissioner represents a different way of working in the NHS.
General Medical Council	The GMC manages the UK medical register, sets professional standards for doctors and doctors in training, ensures that doctors have an annual appraisal (known as revalidation) and investigates doctors when serious concerns are raised.[42] (GMC)
Nursing and Midwifery Council	The NMC is the independent regulator of nurses and midwifery professionals across the UK. It also creates resources to support nurses and midwives in their careers and influences policy in health and social care.
Local authority	Local authorities have a range of statutory functions that can extend to the commissioning and provision of aspects of healthcare. This can be achieved through Section 75 agreements that can include arrangements for pooling resources and delegating certain NHS and local authority functions to partners.

GMMH's standing in the system

11.14 The Trust was generally held in high regard in the system, with its Chair and CEO described to us as active and outward facing. The Trust had a reputation for its strong performance and ability to deliver. The award of Manchester community services to the Trust in 2017 was seen as confirmation of this, and indeed, the Trust has had a reputation as a growing organisation. The Greater Manchester ICS has two of the largest acute trusts in the country. We heard that some system partners wanted there to be a single mental health trust formed to deliver services across the whole of the Greater Manchester footprint, to mirror these enlarged organisations. These views were not necessarily supported by patient and advocacy groups.

11.15 Our review of Board minutes confirmed this external focus. Various interviews with Board members underlined that there was an appetite for further growth and business opportunities. Some people told us that they felt that this emphasis impacted on the time and capacity given to looking at the quality of the services the Trust already had.

11.16 Key interview comments in this area included:

- "*There was a view and conversation in Board that there should be a single trust for GM.*"

- "*We celebrated the chance to get Manchester. We thought if we didn't agree to this growth we would go… it was a survival tactic.*"

- "*The care group structure would help us build on developing further growth and scale.*"

- "*Culturally Manchester [community services] was a massive challenge. We probably hugely underestimated what was needed including "hearts and minds". We just spoke about delivery.*"

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[40] https://www.datadictionary.nhs.uk/nhs_business_definitions/nhs-led_provider_collaborative.html

[41] https://www.kingsfund.org.uk/publications/provider-collaboratives

[42] https://www.gmc-uk.org/about

11.17 The Trust's reputation had been strengthened by the overall CQC rating of Good in 2019. This was taken as confirmation across the system that there were no significant quality concerns, although its Safe domain had been rated as Requires Improvement. We have heard that generally NHS England, previous CCGs, the CQC and Healthwatch felt that the Trust delivered well. Examples given to us included the Trust's response to the system during the pandemic, which was described as helpful and proactive, and the Trust's contribution to its acute partners' emergency departments. Conversely, the neighbouring mental health trust had had a series of reported concerns, including lower CQC ratings. We heard from some system partners that they felt that oversight of this (neighbouring) organisation had taken priority in the system.

What oversight occurred?

Introduction

11.18 This section sets out the roles that the various oversight bodies above played in monitoring the performance of Edenfield and/or the Trust more widely.

CQC

11.19 The responsibility of providing safe care sits with the Trust, while the CQC's main objective is to *"protect and promote the health, safety and welfare of people who use health and social care services"*.' (Health and Social Care Act, 2008). Following the recommendations of the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust and Sir Bruce Keogh's Mortality Review, the CQC completed comprehensive inspections of all NHS trusts. Since then, it has adapted its approach and now inspects service providers according to risk, and to check whether improvements have been made. It also monitors the quality of services based on data available to it, including hard and soft intelligence which is gathered from people making complaints directly to the CQC, those who work in services raising concerns, and from system partners. Further changes are being made to how the CQC delivers its objectives. This has led to changes in roles and how inspection teams are set up.

11.20 Key CQC activity at Edenfield can be summarised as follows:[43]

- **July 2019 – inspection of Adult Forensic Services**. The CQC told us that this was prompted partly in response to concerns raised to them anonymously by staff. These related to staffing levels, burnout, staff not feeling safe to raise concerns with managers, or that the local management response was inadequate. The service was rated as Good overall and Requires Improvement in the Safe domain.

- **December 2020** – There were also concerns regarding the quality of care on Buttermere and Ferndale wards which led to the CQC raising a safeguarding alert and a meeting with the Trust to discuss the concerns.

- **July 2021** – Ongoing whistleblowing from Edenfield staff to the CQC. The CQC shared their increasing and continued concerns about this with the Trust. It is noteworthy that staff from Edenfield were raising concerns directly to the CQC and not through the Trust's internal FTSU routes.

- **September 2021** – The CQC held a meeting with the Chief Nurse and Service Manager from Edenfield. GMMH gave updates regarding Edenfield and actions that were being taken on the unit, including quality improvement projects that were due to be starting. The CQC agreed to receive updates as part of the regular engagement meetings with the Trust.

- **13 to 17 June 2022 – Inspection of Adult Forensic Services**. The CQC did feed back to the Trust its concerns about the management of ligatures at Edenfield on 17 June 2022. The CQC used its enforcement powers to issue a s29A Warning Notice which included issues about staffing and management of ligatures in acute inpatient wards but did not include any action for

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[43] This information is taken from our review of CQC reports, as well as a summary timeline provided to us by the CQC.

Edenfield. It did not identify a breach of regulation in how the Trust was managing restrictive practices. It told the Trust in the report that was published on 24 November 2022, five months after the inspection of the forensic wards, that it should:

- ensure that they have complete oversight and regular reviews of all restrictions placed on patients;

- ensure that they have an accurate and complete picture of all long-term segregation used in the service.

- **25 July 2022** – The CQC issued its high-level feedback letter to the Trust following the well-led inspection. This did not make any specific reference to Edenfield.

- **23 September 2022** – The CQC issued a s29A Warning Notice served at provider level, which included concerns about staffing and oversight of the forensic service. At this time, the CQC suspended all the forensic core service ratings.

- **22 October 2022** – The CQC suspended all the well-led ratings for the Trust.

11.21 We understand that information used by the CQC in its ongoing monitoring of providers and in preparation for inspections varies. Our documentation review found a number of sources of evidence which pointed to clear concerns in Adult Forensic Services over time. These included:

- FTSU cases from Edenfield (since 2018);

- NHS Staff Survey data, which showed the Trust to have some of the lowest scores nationally, and Adult Forensic Services to have some of the lowest scores in the Trust (and therefore the country);

- whistleblowing cases to CQC from Edenfield;

- restrictive practice and seclusion data from Edenfield that were indicators of poor practice;

- exceptionally high turnover of some staff groups in Edenfield;

- the Impact cultural review in specialist services (2019) also showed concerns, although regulators would not be aware of this work unless it were explicitly mentioned to them by the Trust. It is unlikely that this was shared by the Trust with the CQC, given its low profile in the organisation;

- ongoing action from the CQC across the Trust, and the Trust's failure to make the improvements required.

It is unclear how much, if any, of this intelligence the CQC was provided with, although we know that several concerns were raised to the CQC directly by staff from Edenfield.

11.22 The concerns contained in these sources point to various warning signs of a closed culture, as defined in CQC guidance (CQC, updated 12 May 2022). The CQC were aware of some concerns which pointed to a closed culture, including concerns raised directly to them in relation to staffing levels, burnout, care quality and poor leadership. It is also noteworthy that the abuse shown on BBC Panorama was recorded at the same time as the CQC was inspecting the service. However, we are not suggesting that the CQC were on the relevant wards at the time of the covert filming. It would appear that the CQC's approach for assessing closed cultures was not sensitive enough to pick this up and make the necessary impact at Edenfield.

11.23 We note the CQC's different approaches to inspecting various Trust services during the pandemic and shortly after. As stated above, Forensic Services had been rated as Good in July 2019. A planned re-inspection of the service was postponed from January 2022 to June 2022 because of COVID-19. However, in CAMHS inpatient wards, a focused inspection of the Safe domain took place in January 2022, based on intelligence available to the CQC and 'reduced COVID-19 risks'. This inspection was extended to a comprehensive inspection at a time when inspections were risk-

based and no concerns were identified in the Safe domain. This approach was not taken for Adult Forensic Services, where there had been repeated concerns raised regarding staffing, culture and safeguarding of patients since before the meeting the CQC held with the Trust in December 2020. Equally, when concerns were raised about staffing in Adult Community Services, a focused inspection by the CQC took place in April 2022. This resulted in enforcement action.

11.24 We were also curious about the CQC's method for selecting which GMMH inpatient wards to visit; while only seven of 19 forensic inpatient wards were inspected, we understand that all PICU and acute inpatient wards were visited onsite by the CQC. The CQC told us that this was as a result of their sampling method, which they said targeted inspection activity to the wards where there were most concerns.

11.25 The Trust as a whole is now rated Inadequate, following the inspection of three core services in June and July 2022 and a well-led inspection, as well as a series of warning notices. Some stakeholders, and Trust staff, voiced surprise at the perceived change in how the CQC viewed and regulated the Trust after the screening of Panorama, with the feeling that the CQC is now taking higher level enforcement than pre-Panorama. The Trust and stakeholders were under the impression that the CQC inspection had gone well and the high-level feedback letter to the Trust following the well-led review dated 25 July 2022 was generally positive about leadership and culture overall.

11.26 The CQC has finite resources, and we understand that these need to be deployed appropriately. Within this, it has identified various and important observations about where the Trust must improve, including for example, in relation to fire and ligature risks. We would also suggest that there is an opportunity for the CQC to review the information it uses in its ongoing monitoring of providers, and how it uses information to prepare for inspections. This is particularly the case where it is inspecting a service at high risk of developing a closed culture. It should also reflect on how it monitored, shared and responded to the continued and sustained concerns being raised about Adult Forensic Services by staff, alongside the signs that the Trust more widely was struggling to make the necessary improvements.

NHS England and North West Regional Team

11.27 Guidance on national bodies' expected involvement in quality governance is defined in 'Quality Risk Response and Escalation in Integrated Care Systems' (National Quality Board, 2022). It sets out the approach that must be considered by system leaders as they manage quality risks within ICSs. It also confirms the key principles:

- having a clear line of sight, including concerns and risks;

- investing in building an improvement culture;

- having streamlined, agile and lean quality structures which are standardised where possible and support partnership working and intelligence sharing;

- working closely with staff and people using services to support effective quality management.

11.28 The emphasis is on the risk being managed as close to the point of care as possible, and where successful mitigation is not possible describes the process and responsibilities for escalation and management. This is a shift from the previous approach where NHS England was the decision maker for escalating to a single item risk summit. This meeting, where stakeholders discussed emerging risks, has been replaced by a Rapid Quality Review Meeting to rapidly share intelligence, diagnose, profile risks and develop action/improvement plans and may be set up at short notice by ICBs or wider partners (e.g. local authority, NHS England, other regulators), where there is deemed to be a significant or immediate risk to quality, including safety, which is not being addressed in wider discussions.

Figure 21: National Quality Board guidance on quality governance

Place-based assurance focused on pathways. Feed up learning & intel to SQG, escalate issues requiring system response

Regions assure and support management of risks by ICB. Involved if persistent/ serious risks, conflicts of interest, issues wider than ICS (e.g. Risk Summit)

BUSINESS AS USUAL	PLACE QUALITY GOVERNANCE	SYSTEM QUALITY GOVERNANCE	REGIONAL QUALITY GOVERNANCE	NATIONAL QUALITY GOVERNANCE
Providers (community, primary, acute, social, wider) / **Assurance partners (e.g. ICB, LA, providers, NHSE)** / **Safeguarding partners** / **Regulatory partners (e.g. CQC, HEE, GMC, NMC)** / **People, communities, voluntary and independent partners** / **Innovation and improvement partners (e.g. AHSNs, clinical senates)**	**Place-based groups & discussions** Discussions/meetings, improvement and learning focused on quality across pathways and journeys of care. Informs and oversees provider collaborative areas of focus	*System Quality Groups* – Chair: ICB Exec Quality Lead (e.g. Director of Nursing) **Membership includes:** ICB, NHSE regional team, local authorities, CQC, HEE, public health, primary care, maternity specialists, patient safety collaboratives, provider collaboratives, patient safety specialist(s), lay members (x2 including Healthwatch)	*Regional Quality Groups* – Chair: NHS Regional Exec Quality Lead (e.g. Regional Chief Nurse/Medical Director) **Membership includes:** NHSE regional team, ICB Exec Quality Leads, CQC, local authorities, HEE, Health Service Ombudsman, Professional regulators, Healthwatch, OHID and UKHSA	*Executive Quality Groups* – Chair: Chief Nursing Officer/Medical Director) **Membership includes:** NHSE regional team, NHSE national clinical, policy and improvement directors
		Key system partner: Integrated Care Partnership, ICB committee responsible for quality assurance, local authority quality assurance (including Safeguarding Assurance Boards).		

CO-PRODUCTION, LEARNING AND IMPROVEMENT

Provider assurance and risk management remains at provider boards

ICBs accountable for effective management of healthcare risks where do not fall under LA assurance (e.g. safeguarding). SQGs provide joined up quality intelligence and engagement, enable improvement and support response to system risks, escalate to ICB/LA/region as required

Escalation if national response required (incl Recovery Support Programme, approved by System Oversight Committee)

11.29 Due to emerging concerns, NHS England explored with the ICB whether there should be a 'single item risk meeting' to discuss these with the Trust in July 2022. This meeting did not happen, as the system already had an imminent planned meeting, known as the Quality Surveillance Group. In addition, it was highlighted that the CQC was, at that time, inspecting GMMH. It was also underlined that where concerns had previously been raised by the system in relation to GMMH CAMHS, some partner agencies in the system had taken assurance from the positive published CQC report.

11.30 This is further indicative of how CQC inspections have been used in the system, sometimes as a substitute for local, routine and agreed quality oversight processes. It is of concern that more weight was ascribed to the view of the CQC than to other partner agencies, and that the system was prepared to wait for the outcome of the inspection and report. This was a missed opportunity to consider the issues in the prison service, the warning notice for community services and to hear from all involved parties about the Trust's services.

11.31 Finally, we found that NHS England had produced a report (2021) into a mental health trust which was well regarded by the system and had been rated Good by the CQC and was subsequently downgraded to Inadequate. This report made a number of recommendations, including in relation to the importance of information-sharing within the healthcare system, and warning against an over-reliance on the view of the CQC. We found many parallels between the findings in this report and our work at GMMH. We could not see what actions NHS England had taken following this report, to ensure that its learning was shared. This, in our view, amounted to a missed opportunity to improve care at an earlier stage for patients in GMMH.

Specialised Commissioning and provider collaborative

11.32 Until April 2022, NHS England Specialised Commissioning had been responsible for quality oversight of Adult Forensic Services and CAMHS. For Adult Forensic Services, this oversight then transferred to GMMH as the lead provider in the provider collaborative, at which point the Quality and Commissioning Hub, including case managers transferred to the employment of GMMH. This is a new structure, nationally, and most lead providers are still establishing how to enact this role, which involves both a commissioning and a provision function.

11.33 We found, however, various ways in which the provider collaborative could have functioned more effectively. See also Chapter 9 in which we discuss how the Commissioning Committee handled concerns raised to it relating to an independent care and treatment review of an Edenfield patient.

- GMMH entered into a lead provider role without having a permanent Quality Lead in post. We also saw minimal clinical involvement at the Commissioning Committee. This may be indicative that the Trust did not recognise the scale of the quality assurance role it was assuming.

- Some stakeholders told us that the Trust was cautious about its reporting of serious incidents to the provider collaborative. As lead provider, it is important that the Trust sets a tone of openness and transparency. It is not clear whether this view was reported to Specialised Commissioning or the NHS England Regional Team.

- NHS England undertook due diligence before making GMMH lead provider, though the process did not identify that there had been quality and staffing concerns in its specialist services which are outlined throughout this report, and it remains unclear how explicitly case managers had been escalating this, to either Specialised Commissioning or the provider collaborative.

- As outlined in Chapter 8, potential conflicts of interest in the Commissioning Committee do not appear to have been managed robustly. Various meetings of the committee were cancelled.

11.34 The GMMH Lead for Commissioning raised the concerns from the IC(E)TR, described in Chapter 9, with NHS England North West Specialised Commissioning, Health and Justice on 30 June 2022. Specialised Commissioning personnel also shared the concerns with NHS England nationally which led to a memo being sent to Directors of Learning Disability and Autism and Mental Health about the bullying from staff, explicitly mentioned a closed culture in the unit, and that the unit had been identified "*as an area of good practice by NHS England as part of the blended model pilot*". This flagged the possibility that the Trust needed closer scrutiny, as these concerns had emerged unexpectedly. However, the NHS England North West quality team and the Regional Director with responsibility for Mental Health and Learning Disability were not informed directly of the detailed concerns from the IC(E)TR until September 2022.

11.35 In February 2023, NHS England Specialised Commissioning issued a contract performance notice to the Trust as they were concerned about the lack of a detailed improvement plan for Edenfield. NHS England Specialised Commissioning told us that they sent copies of this letter to NHS England colleagues, the CQC and the ICB.

Integrated Care Board

11.36 Until April 2022, there was a lead CCG identified for monitoring quality of care. Meetings were held every quarter where key quality metrics were analysed, such as complaints, performance and GP feedback. We heard that the Trust always performed well on quality and would have a clear recovery plan if performance was off-track. We note, however, the high degree of open serious incident cases held by the Trust. We were told that this was likely due to the Trust having low thresholds for declaring a serious incident, which is incompatible with the feedback we heard from staff.

11.37 Following Panorama, the ICB undertook a desktop review of key quality metrics to understand if it had missed any important 'red flags' at GMMH. We were told that two key findings emerged from this exercise:

- Having looked at quality metrics they had historically reviewed at GMMH, the ICB found that there were no sources of intelligence that had been 'missed', including safeguarding referrals, CQC activity, and FTSU cases.

- The complexity of commissioning of GMMH services became apparent, with various different bodies overseeing different GMMH services, all in receipt of different sources of intelligence. We were told that commissioners were not sharing information effectively with each other in any routine or structured way.

11.38 This last point underlines that the ICB is monitoring quality at a very high level and would not routinely receive some of the more worrying sources of information we identify earlier in this chapter. We understand that some of the performance oversight arrangements sat with a committee known as the Greater Manchester Provider Federation Board. This was composed of all providers from Greater Manchester, who monitored and evaluated their own performance. We believe that this model has now been amended and recognised as ineffective.

11.39 We were also struck by the lack of senior mental health expertise in the CCG's (now ICB's) quality oversight team. It is important that this is brought into the new quality oversight structure so that there is the necessary expertise to clearly understand what the data from the Trust is telling commissioners. A good example of this is restrictive practice and seclusion data, which does not seem to have featured in the ICB's retrospective desktop review.

11.40 We set out earlier in our report the significant financial challenges that the ICB is facing across Greater Manchester. The ICB has a clear role in the oversight and performance of NHS providers, and we were interested in how this was developing across Greater Manchester. Recently the ICB has been made aware of several improvements that it could make to improve some of its core functions. These include:

- developing a more cohesive set of data and performance measures for provider organisations;

- improving the quality of information and data for mental health services;

- improving how different parts of the system both understand and relate to each other including aspects of the governance structures; and

- developing a more structured approach to performance monitoring.

11.41 We were told that the ICB is still in the process of developing its quality oversight structures at the time of our review. In our view, three important points emerge from this which the ICB should take forward in the development of its governance structures:

- It is important that all commissioners of GMMH services share their intelligence with each other.

- The lack of information from safeguarding and FTSU should have been cause for further investigation, rather than taken as signs of positive assurance.

- The patient voice was missing in the oversight of the Trust. Patient groups, advocates and complaints processes had all highlighted issues which later came to light in Panorama.

Local authorities

11.42 Greater Manchester is made up of ten local authority areas, each one of which has its own place-led priorities which collectively support the city region. Five of these local authorities have a direct relationship with GMMH. Local authorities have a range of statutory functions that can extend to the commissioning and provision of aspects of healthcare. This can be achieved through Section 75 agreements that can include arrangements for pooling resources and delegating certain NHS and local authority functions to partners.

11.43 We heard that the current arrangements for working with the Trust have been difficult, with variable engagement at executive and care group level. We were told these arrangements have proved more challenging since the Trust expanded. More recently, the Directors of Adult Social Services (DASS) have sought to develop a more cohesive strategic relationship with the Trust, aligned to a more collaborative approach at service level. We were told that this was, in part, influenced by difficulties in the current governance arrangements and a view that some staff feel disconnected from their Council as their employer.

11.44 The DASS recognise the difficulties for the Trust in working across five local authorities and have asked for greater ownership from GMMH at executive level regarding the Section 75 agreements in place. They have expressed concerns regarding the delivery of community services and are

working with the Trust to develop more effective oversight and governance arrangements in relation to the delegated duties from the councils to the Trust.

Nursing and Midwifery Council (NMC)

11.45   The NMC is the independent regulator for nurses and midwives in the UK, and nursing associates in England. It receives referrals where there are concerns about a nurse's practice. We asked the Trust for details on how many nurses it had referred to NMC between April 2020 and March 2023. The Trust told us it was 89. We asked the NMC for the same data and it told us they had received 63 referrals between April 2020 and March 2023. Some of these referrals came from routes other than the Trust, which means there is a discrepancy in the data. The NMC told us that there are many variables which make it difficult to comment on or compare the number of referrals received and it is also difficult to compare trusts against one another as they will offer a variety of services, use different models of employment for staff and have distinct workforce sizes. We believe this seems a relatively high number of referrals for one organisation in a three-year period.

General Medical Council (GMC)

11.46   The GMC is the independent regulator for doctors in the UK. The GMC had not received any referrals (and so there are no open cases) recorded against Edenfield. Between April 2020 and March 2023, the GMC received 31 complaints recorded against GMMH, of which one remains in progress.

Conclusion

11.47   Our review found clear indications that there had been long-standing quality and cultural issues at Edenfield. These were happening in the context of a Trust which was struggling to make and sustain improvements across various services. National and legislative changes to the way that health services are monitored, as well as the pandemic, had led to the oversight of the Trust being reduced.

11.48   Different bodies were in possession of different sources of information about the Trust, and it appears that these could have been shared in a more purposeful and systematic way to ensure a clear picture of service quality.

11.49   Actions taken by other stakeholders have followed action taken by the CQC and do not appear to have been taken independently, based on their own findings and monitoring.

11.50   In effect, there were several warning signs at Edenfield which could have been picked up and acted on sooner, not least by the Trust's internal quality governance structures. These include:

- patient concerns and complaints being raised;

- potentially high levels of restrictive practice and potentially very long seclusion and segregation rates;

- some of the lowest staff survey scores in the country, including around psychological safety;

- high turnover of staff;

- a dearth of FTSU cases (yet reporting of these to the CQC); and

- a lack of safeguarding referrals.

11.51   All of these indicators are suggestive of a closed culture, as defined by the CQC. The methods used by the CQC in its oversight of the service do not appear to have been sensitive enough to pick these up in a timely way nor to inform their initial ratings or enforcement activity.

11.52   Similarly, there were signals that the Trust more broadly was facing challenges which do not appear to have impacted on stakeholders' views. These included:

- CQC warning notices, that were not being closed on a timely basis;

- high numbers of open serious incidents, with action plans not being closed on a timely basis;

- inpatient deaths, including of three young people on CAMHS wards;

- concerns that learning was not taking place, which were flagged by the coroner in Prevention of Future Death Notices. As referenced earlier in this report, between January 2020 and February 2023 GMMH received 17 Regulation 28 reports;

- some of the lowest NHS staff survey results for mental health trusts nationally;

- exceptionally high nursing vacancies; and

- all of these issues occurring after the Trust's rapid growth.

11.53   In writing this chapter, we acknowledge that, since March 2020, the NHS has faced its biggest challenge, in dealing with the pandemic and its aftermath. The recovery of services post-pandemic has had to happen during a period of enormous change in the health and care landscape. This was echoed by a system leader we interviewed who said that "*whilst we have a great deal to do, the system lacks compassion. The Trust needs to organise itself to support the five place areas, but system partners need to be more sensitive to the pressures we are under.*"

11.54   However, it is difficult to see how the system identified, joined up and responded to warning signals about the Trust and Edenfield specifically, prior to Panorama. Restructures made since the Health and Care Act 2022 provide an opportunity to reset quality oversight processes, so that partners can ensure that they are assessing care quality through the lens of patient experience.

11.55   This report has set out how connected the issues are that led to the failures of care. The next chapter sets out our recommendations for the Trust so that it can make the changes needed to create sustained improvements.

Chapter 12 Recommendations

Overview

12.1   We have used a systems-based approach in completing this review. We wanted to show that the issues we identified are not independent of each other but interconnect and influence each other. In order to achieve the improvement needed to provide high-quality care, the recovery plan must consider these recommendations in combination and not as stand-alone actions. This is why we have placed all the recommendations together in one chapter and not isolated them at the end of each chapter. Within this review, 'quality' is taken to encompass safety, effectiveness, and a positive patient experience.

12.2   Each recommendation refers to areas for improvement identified during this review; they are blended to allow the Trust flexibility in their practical implementation and are described to encourage a system-based approach to make many of the changes needed. Their design also allows for some local determination by the Trust. However, it also recognises that GMMH is in a period of transition and will require ongoing support to ensure it understands the scale of the changes required. Assurance will be based on an assessment of the evolution of these systems against their aims.

12.3   Each planned improvement must have clear aims, a set of actions to be taken to achieve them, and an evaluation to show progress towards the aims. The Trust has previously used the mantra: "*clinically led, managerially partnered and academically informed*", which was well recognised by staff we spoke to. It seems pertinent to many of the improvements required, and the Trust may wish to reignite the use of this strapline in its continued journey.

12.4   In implementing our recommendations, a fundamental component will be supporting GMMH in continuing to create a culture of improvement. This will not happen overnight, and stakeholders and partners will need to work alongside each other in enabling GMMH to thrive and safely manage risk.

12.5   The Board and system partners must assure themselves that GMMH has the capacity and capabilities to deliver these recommendations. We would strongly recommend that the Board encourage the Trust to look to organisations external to themselves to find best practice that they might take and adapt into their services.

12.6   Due to the complexity and scale of work the Trust knows it must do, in conjunction with an already significant improvement plan, the recommendations we make in this chapter focus on actions the Trust must commence over the next 12 months to build solid foundations for a sustained improvement journey. The review team will undertake an assurance visit in approximately 12 months' time to determine the progress made.

Patients, families and carers

12.7   **Area for improvement:** The Trust has not kept patients, families and carers at the centre of their service delivery. It missed opportunities to hear the voices of patients, families and carers when services failed to meet expectations and, in the case of Edenfield, care has sometimes been abusive, unkind and unsafe. The Trust's previous strategies in relation to engagement with patients, families and carers have not been fully effective.

> **Recommendation 1:** The Trust must ensure that patient, family and carer voices are heard at every level of the organisation. The Trust must respond quickly when people experience difficulties with the services they receive and make lived experience voices central to the design, delivery and governance of its services. They have developed a strategy in this area, which now needs to be implemented and evaluated to understand its impact.

12.8   The Trust must continue to work on these areas in the first year:

- Carry out a full appraisal of the Service User Engagement Strategy with all relevant stakeholders to ensure that its aims are being delivered and that it meets the needs of the

Trust's communities. This evaluation must assess the degree of cultural sensitivity and responsiveness enabled by the strategy.

- Systems to represent and respond to patients' expertise at every level of the organisation.

- Systems to represent and respond to family and carers' voices at every level of the organisation.

Clinical leadership

12.9 **Area for improvement:** The voice of clinicians is undervalued and weak in the Trust. We heard this from all professional groups, and especially from direct care nursing staff. It has been further muffled by a more dominant operational voice. The organisation needs to develop and nurture a strong clinical voice that is present at every level and in every forum across the organisation, so that clinical quality is at the centre of every decision made.

Recommendation 2: A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.

12.10 The Trust must continue to work on these areas in the first year:

- Systems for developing robust clinical leadership, which includes a clear understanding of roles and responsibilities and expectations.

- System of high-quality supervision, mentoring and coaching to support clinicians undertaking clinical leadership roles.

- Evaluate the effectiveness of the care group triumvirate model.

Culture

12.11 **Area for improvement:** The culture of an NHS organisation is determined by the Trust Board. This Board allowed a dysfunctional executive team with a culture that valued operational performance above clinical quality. The Board did not balance its responsibilities to its external environment with its responsibilities to its internal quality of services. Furthermore, the Trust has had a poor patient safety culture, and we heard consistent reports of management behaviours at every level across a number of services that have discouraged and suppressed staff speaking up about quality concerns. This has had a major impact on the Trust's ability to deliver safe care. The Trust has not always provided an equitable experience and opportunity for their staff with protected characteristics.

Recommendation 3: The Board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership from Board to floor. This culture must ensure that no staff experience discrimination.

12.12 The Trust must work on these areas in the first year:

- The Board must reflect on the findings of this report and what happened at Edenfield in order to develop a clear set of expectations about the values and behaviours expected from all staff working within the organisation.

- Develop systems that deliver and measure key aspects of culture so that staff and leaders can be held to account for demonstrating values and behaviours that support the development of a new and healthy organisational culture which encourages and listens to people.

- The organisation must work with staff to develop systems which support a culture of inclusion and engagement that addresses concerns in relation to equality and racism.

- Review the current leadership programme and ensure that its content covers these key areas. Prioritise this programme's delivery.

Workforce

12.13 **Area for improvement:** The Trust is failing to provide an environment that supports staff to provide high-quality care and maintain their health and wellbeing. The national staffing crisis is likely to remain an ongoing issue for some years, and this reality must be factored into the improvements that the Trust can make in its workforce planning. Adaptations will need to be made to account for this, such as consideration of the training and supervision of temporary staff, as well as permanent staff.

Recommendation 4: The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, including ensuring the stability of nursing staff. The Trust must develop a representative, competent and culturally sensitive workforce which is supported to provide services that meet the needs of its communities.

12.14 The Trust must continue to work on these areas in the first year:

- Develop a strategy for the recruitment and retention of staff and an associated delivery plan; with systems to support the Trust to understand the potential impact that unstable staffing (particularly among nurses) has on the quality of their care and to adapt to these challenges.

- The systems to ensure that staff are encouraged to speak freely and that they are listened to when they raise areas of concern or areas for improvement.

- The systems to ensure that staff have the right knowledge, skills, supervision and mentoring to perform their roles.

- The systems to ensure that staff health and wellbeing are supported.

12.15 We know that the quality of the environment impacts on patients, their families and the workforce; a number of the buildings within the Trust estate are no longer fit for the purpose of providing modern mental health care. The Trust is undertaking some rebuilding to improve their estate. However, buildings are not always maintained to a standard that allows services to be delivered safely, and issues with the fabric of buildings are not always reported and if reported not always maintained in a timely way. Where safety critical maintenance is not being undertaken, mitigation should always be considered to manage risks that this creates. Ward environments are not always clean and uncluttered.

Recommendation 5: The Trust needs to have a better understanding of the quality of its estate and the impact of this on the delivery of high-quality care, including providing a safe environment. It must ensure that essential maintenance is identified and carried out in a timely manner and that the cleanliness of units is maintained.

12.16 Within the first year the Trust must continue to:

- The Trust Board must assure itself about the quality of its estate and safety within it.

Governance

12.17 **Area of concern:** The current (and historical) governance structure has not been effective in escalating information in ways that are sufficiently timely, clear or useful. The reasons for this are twofold. Firstly, that the structures and processes in place are unclear, including a poor use of data and intelligence to understand the current quality of services. Secondly, the organisational culture has inhibited the raising of concerns at every level. This has had a significant detrimental impact on the Trust's ability to learn and improve in its services.

Recommendation 6: The Trust must ensure that its governance structure (and the culture that this is applied within) supports timely escalation and that the right information can be used at the right

level, by the right staff. There must be much greater focus on the validation and triangulation of information to ensure that quality issues can be resolved quickly and learning can take place.

12.18　The Trust must continue to work on these areas in the first year:

- Ensure that governance functions (including, but not limited to, safeguarding and complaints) are adequately resourced to meet the needs of the size of the Trust.

- Ensure that the governance framework supports the necessary information flows for staff at all levels to manage and improve quality (from Board to floor).

- Develop systems that proactively scan for safety concerns across its services, using and triangulating a range of information and intelligence sources: including, but not limited to, safeguarding referrals, complaints, staff and patient surveys, staffing levels, FTSU cases, and incidents.

- Design a quality management system to enable the systematic planning for, maintaining and improving quality.

Edenfield

12.19　**Area for improvement:** Edenfield has not been able to consistently provide the forensic services that its patients need and deserve. At times, services there have been unsafe, unkind and abusive to those using them. Management behaviours have actively discouraged and suppressed concerns being raised and there has been long standing dysfunction in the consultant group, which has impacted adversely on relationships and consultants' leadership.

12.20　The national staffing crisis is likely to remain an ongoing issue for some years, and this reality must be factored into the improvements this service must make. Adaptations will need to be made to account for this, such as consideration of the training and supervision of temporary staff alongside permanent staff.

12.21　The journey to developing the high-quality service patients, families and staff want it to be will take time. The improvements required will need to be sequenced to ensure that they can be sustained over time. We encourage the service to look outside itself to find best practice within other organisations.

Recommendation 7: The Trust must ensure that Edenfield provides compassionate, high-quality care and that all staff, permanent or temporary, have the skills, knowledge, and support to achieve this.

12.22　The enhanced leadership team have made a good start on Edenfield's recovery and need to continue to build in the following areas over the next year:

- The clinical model to deliver best forensic practice.

- The systems that deliver and measure key aspects of culture with particular emphasis on compassionate, high-quality care and a positive patient safety culture.

- The systems to ensure that the lived experience and expertise of patients and families are central to the work of the service.

- The use of data and intelligence that gives leaders meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.

- The systems that encourage staff to report quality concerns and improvement ideas.

- A review of advocacy services in Edenfield to ensure that they are delivering the intended benefits for patients there which includes how leaders value advocacy.

- The systems that support all staff, including those who are temporary, to work effectively in multi-professional teams. This should include consideration of training, supervision, mentoring, coaching, reflective practice and wellbeing.

- The systems that ensure that the internal environment is clean, safe and fit for purpose.

Improvement plan

12.23 **Area for improvement:** The current improvement plan is large and ambitious. The problems the plan is trying to solve are not clearly defined, and actions often lack appropriate consideration of how their impact will be evaluated. Prioritisation is not focused on what would make the most difference to the quality of care for people using services, or the experience of people working in these services. Already, some actions have not been completed in the timeline described. The safe and sustainable delivery of this plan is fundamental to rebuilding the trust of stakeholders (including patients and staff) in the organisation.

Recommendation 8: The Trust should review the improvement plan again following receipt of this report's findings to develop further clarity about the problems that they are trying to solve and the actions that need to be taken to achieve better outcomes. It needs to be clear on how all actions will be evaluated so that it can be assured about whether changes being made are having the desired impact. The plan should be prioritised to ensure that actions are sequenced, build on each other, and prioritise the quality of care people receive from GMMH. This includes ensuring a balanced approach between the scale of the improvements required and setting out a realistic timescale for implementing identified actions with the support of their system partners.

12.24 The Trust must continue to work on these areas in the first year:

- Articulate clearly the problems the Trust is trying to resolve. This process needs to involve clinicians and service users.

- Ensure that impact measures are clearly defined and that the Trust knows how it will measure them.

- Ensure the plan is prioritised, sequenced, and the first 18 months of work are described clearly.

Elsewhere in the organisation

12.25 **Area for improvement:** In each area we were struck again by the commitment of staff and their desire to improve their services. We found evidence of concerns in all of the services we visited. Some of these reminded us of the culture and working practices at Edenfield, which precipitated the abuse and poor treatment of patients which Panorama uncovered (such as low levels of staffing and psychological safety).

Recommendation 9: We identified some common concerns across services we visited at the Trust, which were also prevalent within Edenfield. The Trust and the wider system must consider how they understand issues identified in these services (and others) in more detail, including through the actions described below.

12.26 Within the first year:

- The Trust should urgently review how it identifies safety concerns and initiates sustainable learning when people die unexpectedly while using their inpatient services.

- The GMMH Board needs to immediately ensure that it has an up-to-date and accurate view of the current levels of safety within each of the services referenced, and controls in place to address any immediate risks. This should include a re-assessment of the effectiveness of their ligature reduction plan.

- NHS England should consider whether they, and GMMH, require a more detailed review of deaths across both inpatient and community services to ensure that safe care is being provided and to maximise every opportunity to learn, in line with contemporary practice.

- As a second stage review, the Trust and its partners should identify together where and in which services further independent assurance is needed. We recommend that Community Mental Health Services are independently reviewed.

System oversight

12.27 **Area for improvement:** The organisations external to the Trust that have responsibilities for regulating, overseeing quality, and supporting providers did not identify and respond to the failings happening within GMMH prior to BBC Panorama airing. We consistently heard that the Trust had a reputation for strong performance and its ability to deliver, despite there being signals of significant quality concerns across several of the Trust's services. The regulator did not identify some of the key safety issues in relation to closed cultures and poor patient care.

Recommendation 10: The organisations with responsibility for regulation, oversight and support to GMMH must review their current systems of quality assurance. They must also review how they work together collectively to identify concerns in a provider at an early stage to prevent tragedies like those seen at Edenfield from reoccurring. Where learning is identified that applies nationally, this must be cascaded by the relevant organisation.

12.28 There are a number of areas that must be implemented in the first year:

- Within each organisation discussed in this report, review the assurance architecture for the oversight of GMMH and consider why this failed to identify workforce, culture, and quality concerns at an earlier stage.

- The ICB should review the level of mental health expertise it has in its oversight of mental health organisations, ensuring that its staff have the relevant experience and seniority to be able to identify leading quality concerns in providers.

- The CQC must define why their oversight of the Adult Forensic Service did not identify a closed culture or that the service was at risk of developing one, as per their definition.

- Redesign systems to support better partnership-working between external agencies, so that information is shared and understood in a timely way to identify potential services in distress.

- Review how the system supports the Trust to ensure that their approach is focused on enabling the Trust to identify priorities, make the improvements needed, and model, at a system level, the compassionate leadership that is required to achieve sustainable change.

12.29 **Area for improvement:** The Greater Manchester Adult Secure (Northwest) provider collaborative, in its present format, is not effectively fulfilling its quality oversight responsibilities, and lacks the necessary clinical input to support this role. There appears to be an overall lack of clarity about the purpose of the collaborative and the subsequent governance structures required to support the delivery of this role. GMMH acts as the lead provider within this collaborative.

Recommendation 11: NHS England must review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise. In light of the concerns identified in this report in relation to Adult Forensic Services (and wider issues in the Trust's Specialist Services), the role of GMMH as lead provider needs to be reviewed by NHS England. If this arrangement is to continue, support should be provided to GMMH to stabilise the current situation and to develop it to deliver the role effectively in the future.

12.30 There are a number of areas that must be reviewed in the first year:

- NHS England must review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role.

- Review GMMH's position as lead provider in the provider collaborative.

- NHS England should develop a Standard Operating Procedure within six months to provide clarity around the thresholds for information sharing and escalation of concerns (e.g., relating to IC(E)TRs, and include Contract Performance Notices and other sources) when issued in relation to patient care.

Chapter 13 Conclusion

13.1   We hope that this review will support GMMH to provide high-quality services to the people and communities they serve. We know from listening to so many people, that this is what their staff want, it is what their patients, families and carers want, and it is what their communities deserve.

13.2   A fundamental change in emphasis is required to achieve this. The priority must be on people, on quality, and it must be on listening to those who use and work in their services. The Trust has many positive attributes, not least its many talented staff. It must focus on enabling those staff to thrive. This will require a significant cultural shift if the required changes are to happen successfully. The scale of this should not be underestimated. We have seen some signs that the changes are starting to happen and, if sustained, this is a positive step forward.

13.3   We heard from some that staffing at the Trust is too constrained to meaningfully change culture. Our view is that culture starts with the Board which dictates the tone of the organisation, what is important, the extent to which staff feel listened to, and the priority given to continuously improving services.

13.4   The partner organisations that work alongside the Trust must also focus on supporting GMMH to make improvements and model the compassionate leadership that is required to achieve sustainable change. These will not be achieved by ticking a box in an action plan; the change will be made by creating a vision and a future for the Trust that people believe in.

13.5   Finally, we were drawn to the words of Dr Bill Kirkup: "*The first step in the process of restoration is to accept the reality of what has happened. The time is past to look for missing commas in a mistaken attempt to deflect from findings.*" (Kirkup, 2015). GMMH must adopt a similar philosophy and with this, positive change will come. We hope the Trust will use this review to reflect on what has happened and to now focus on the future and the changes that need to be made.

Appendix 1 – Review terms of reference

Background

The following terms of reference are for an independent review regarding failings of care and treatment provided to patients at Greater Manchester Mental Health NHS Foundation Trust, with the Edenfield Centre being the primary focus of the review.

While the Edenfield Centre is the focus, the review will also determine if, in identifying any issues regarding patient care or the oversight of quality, this indicates concerns in other areas of the Trust. This will be informed by evidence and information obtained from key parties including patients, families and staff.

Professor Oliver Shanley OBE ('the Chair') is appointed by NHS England to chair the independent review. The Chair will appoint those with appropriate experience to help deliver these terms of reference, including:

- An expert panel and specialist advisers

- Secretariat functions to be delivered by Niche Health and Social Care Consulting

The review findings will be informed by hearing directly from patients, families, and staff to understand their concerns, and how Greater Manchester Mental Health NHS Foundation Trust has responded to these.

Purpose and scope of the independent review

To undertake an overarching independent review that will deduce, scrutinise and assess areas of concern. It will focus on how these incidents were able to happen and why the failings were not picked up. Crucially, the review will provide:

1. An independent assessment of what has happened within the Trust's secure services and identify conclusions and lessons. This assessment will ensure it identifies the actual reality of care for patients and staff.

2. An assessment of the culture, leadership, workforce planning and governance that may have impacted on the ability of the Trust to improve patient safety, treatment, and care, including how the Trust involved patients and families. This will include observations on culture that may have led to failures in professional standards.

3. An assessment of the adequacy of the actions taken by the Trust since the concerns were raised. This will include whether the Trust can demonstrate broader organisational learning to improve the quality of its services.

4. The review will consider whether the processes, actions, and responses of regulators, local commissioners, NHS England's Specialised Commissioning function, and other stakeholders relevant to the provision of secure services were satisfactory in responding to and predicting concerns about the quality of care.

5. Whether the Trust's current systems, processes and controls would give rise to the identification of similar issues now (and going forward) in all areas of care delivery.

6. Whether the issues identified in 1 to 5 above indicate concerns in other areas of the Trust.

The review period will consider any concerns that have been raised from April 2021 to March 2023, including, but not limited to, HM Coroner. The review will aim to provide assurance to patients, families, staff and the broader public regarding the quality and safety of services provided by Greater Manchester Mental Health NHS Foundation Trust.

Methods and approach

The independent review will focus on the experience of the people and families affected and the response of the Trust. This will have reference to clinical standards for mental health care during the period including, but not limited to, areas such as the use of restraint, seclusion, record keeping, and restrictive practices. The independent review will listen to the concerns of the affected patients and families, use their experience to inform the key lines of enquiry, and provide an opportunity for them to be heard.

The review will consider both quantitative and qualitative information, notably the lived experience of patients, families, and staff. The review team will use a range of recognised patient safety approaches to learning from incidents in line with best practice. Importantly, this will be underpinned by a commitment to compassionate engagement and involvement of those affected.

The independent review will also consider and report upon any good and notable practice observed.

Outcome of the review

Taking account of improvements and changes made, the review will aim to provide lessons helpful to Greater Manchester Mental Health NHS Foundation Trust, but also more widely where there are broader opportunities for improvement.

The review will submit a report to NHS England by September 30, 2023, which will include:

1. A full assessment against all aspects of these terms of reference

2. A description of the evidence used to underpin those findings

3. The identification of any areas of good practice

4. The identification of any care or service delivery problems

5. A full suite of agreed actionable recommendations, where deficits have been identified

6. A proposal to conduct an assurance follow up visit with key stakeholders 12 months after publication of the report, to assess implementation and monitoring of associated action plans.

Appendix 2 – National Staff Survey – analysis and benchmarking

We analysed the GMMH results from the National Staff Survey from both 2022 and 2021. The latter was to understand if there had been a significant deterioration of staff responses following the BBC Panorama broadcast.

In one exercise, we compared GMMH's scores against all other English mental health trusts' scores. In a following exercise, we compared the scores of GMMH Forensic Services with those of the Trust's other inpatient services.

In this appendix, we have shown some key findings arising from this analysis.

1. **People Promise 4 – We are safe and healthy.**

   In 2022, GMMH scored 5.8 on People Promise 4. This is the second lowest score of all NHS England mental health trusts. The 2022 GMMH score for People Promise 4 has decreased by 0.2 since 2021, when it obtained the sixth lowest score of all NHS England mental health trusts.

   In 2022, GMMH scored 0.4 lower than the Northwest average and 0.5 lower than the National average.
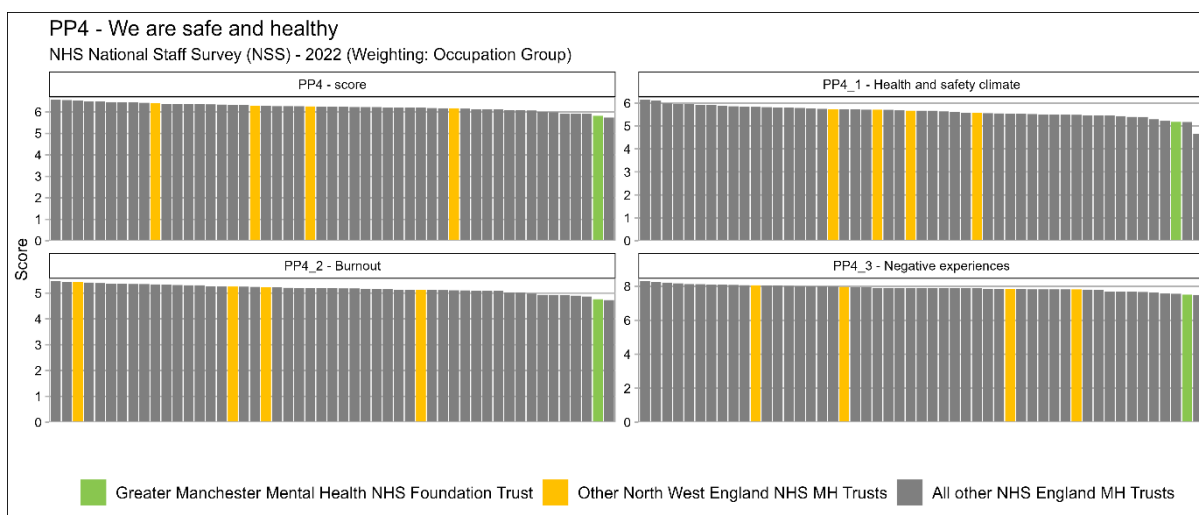
2. **People Promise 5 – We are always learning.**

   In 2022, GMMH scored 5.3 on People Promise 5. This is the third lowest score out of all NHS England mental health trusts. The 2022 GMMH score for People Promise 5 has decreased by 0.2 since 2021, where it obtained the 14th lowest score of all NHS England mental health trusts.

   In 2022, GMMH scored 0.2 lower than the Northwest average and 0.4 lower than the National average.

3. Staff engagement

In 2022, GMMH scored 6.5 on Staff Engagement. This is the second lowest score out of all NHS England mental health trusts. The 2022 GMMH score for Staff Engagement has decreased by 0.4 since 2021, where it obtained the fifth lowest score out of all NHS England mental health trusts.

In 2022, GMMH scored 0.5 lower than the Northwest average and 0.6 lower than the National average.

4. Morale

In 2022, GMMH scored 5.5 on Morale. This is the second lowest score out of all NHS England mental health trusts. The 2022 GMMH score for Morale has decreased by 0.3 since 2021, when it obtained the seventh lowest score out of all NHS England mental health Trusts.

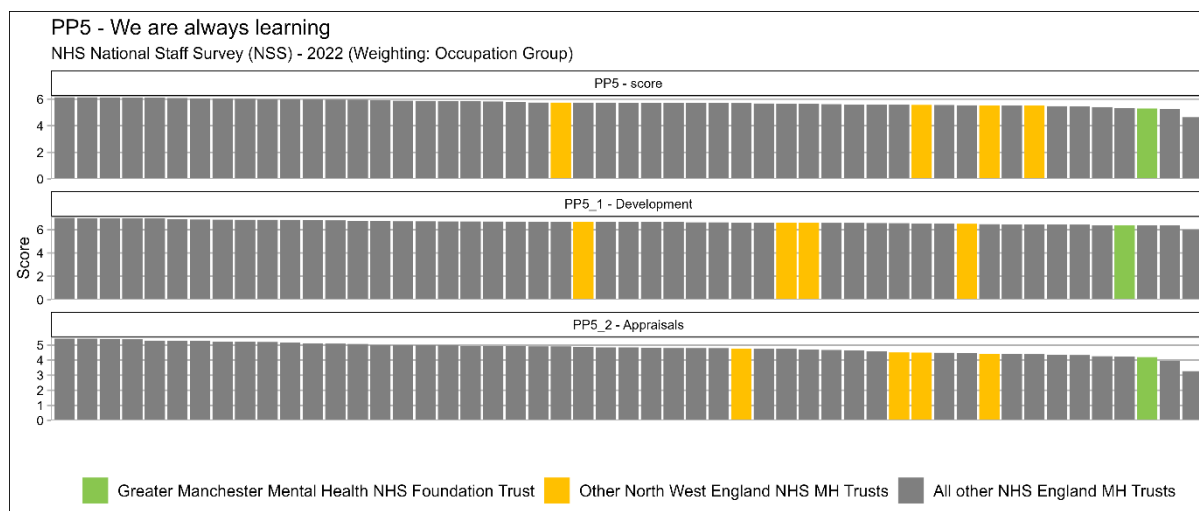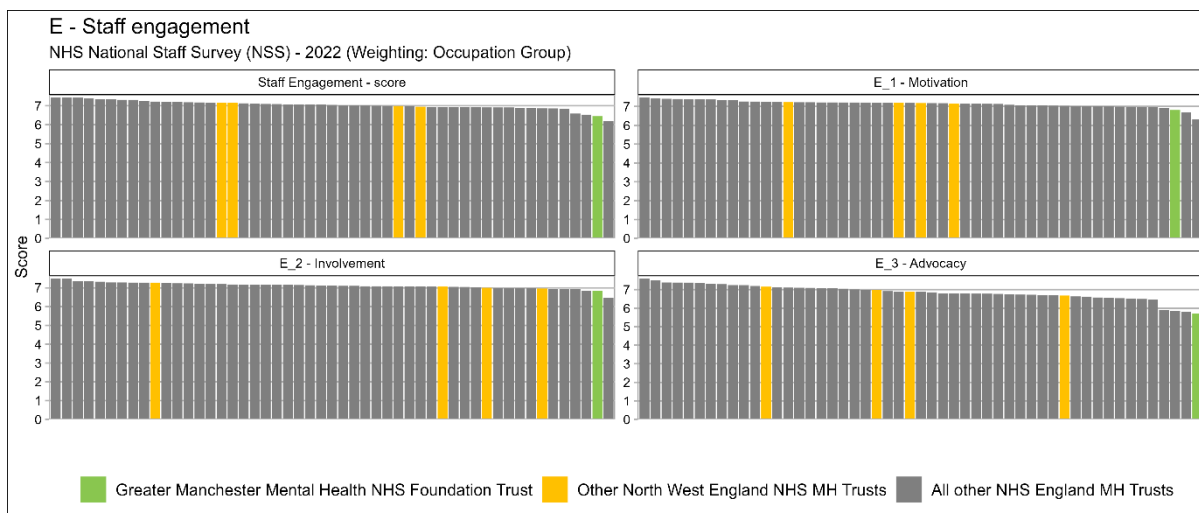In 2022, GMMH scored 0.4 lower than the Northwest average and 0.5 lower than the National average.

5. There are enough staff at this organisation for me to do my job properly. (Trust response)

In 2022, 57% of staff disagree or strongly disagree that there are enough staff at GMMH to do their job properly. This is the fourth highest percentage when compared with all other NHS England mental health trusts and is 4% higher than in 2021 (when GMMH had the seventh highest percentage).

In 2022, GMMH had 7% more than the Northwest average and 6% more than the national average either disagree or strongly disagree that there are enough staff at GMMH to do their job properly.

In 2022, GMMH had 24% of staff agree or strongly agree that there are enough staff at GMMH to do their job properly and 19% neither agree nor disagree.
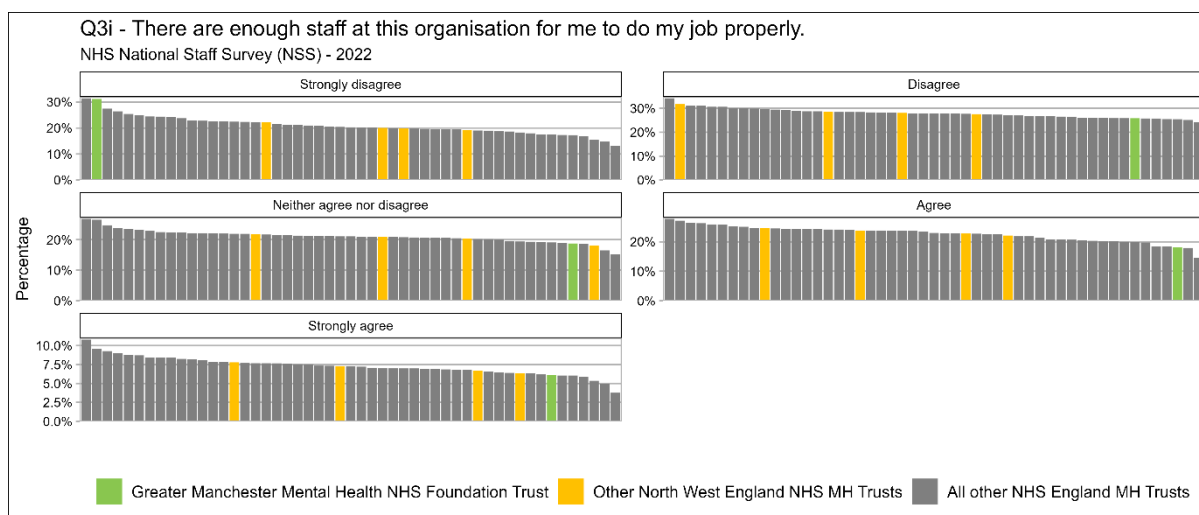
6. There are enough staff at this organisation for me to do my job properly. (Internal benchmarking)

In 2022, Forensic Services averaged 85% of staff disagreeing or strongly disagreeing that their organisation has enough staff. Compared with all other GMMH services, Forensic Services had the fourth highest percentage (out of 60 services), with the percentage significantly higher in 2021 by 28%.

In 2022, Forensic Services had 16% more than the inpatient services average and 28% more than the GMMH average either disagree or strongly disagree that the organisation has enough staff.

The Medium and Low Secure services had 88% of staff disagree with the statement, whereas the Women's Blended Service had 67% disagree.

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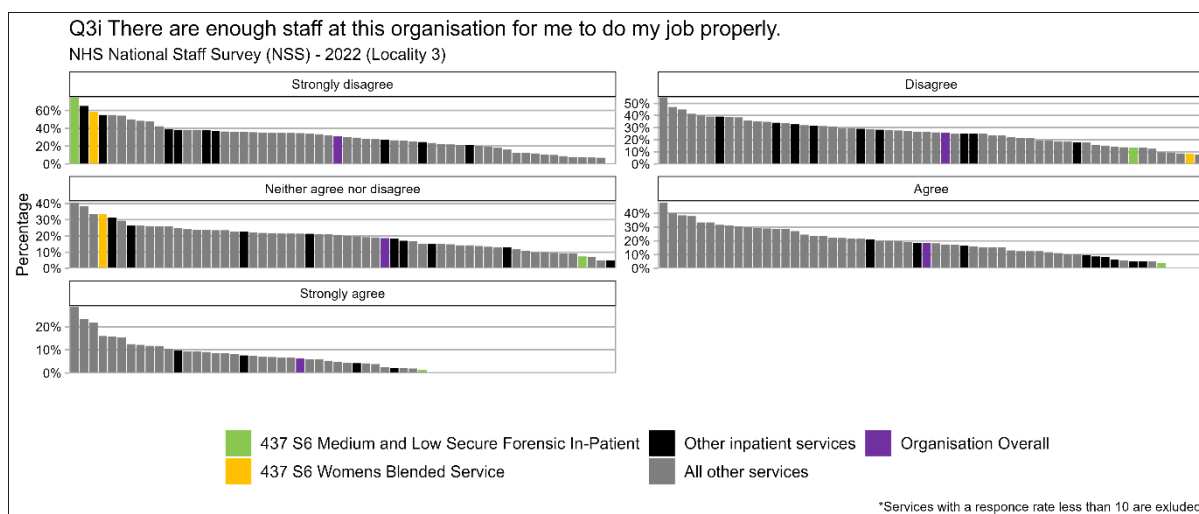
7. During the last 12 months have you felt unwell as a result of work-related stress? (Trust level)

In 2022, 53% of staff answered yes when asked if they have felt unwell as a result of work-related stress in the last 12 months. This is the second highest percentage when compared with all other NHS England mental health trusts and is 4% higher than in 2021 (where GMMH had the sixth highest percentage).

In 2022, GMMH had 10% more than the Northwest average and 11% more than the national average answer yes when asked if they have felt unwell as a result of work-related stress in the last 12 months.

In 2022, 47% of GMMH staff answered not when asked if they have felt unwell as a result of work-related stress in the last 12 months.

Q11c - During the last 12 months have you felt unwell as a result of work related stress?
NHS National Staff Survey (NSS) - 2022

Legend:
- Greater Manchester Mental Health NHS Foundation Trust
- Other North West England NHS MH Trusts
- All other NHS England MH Trusts
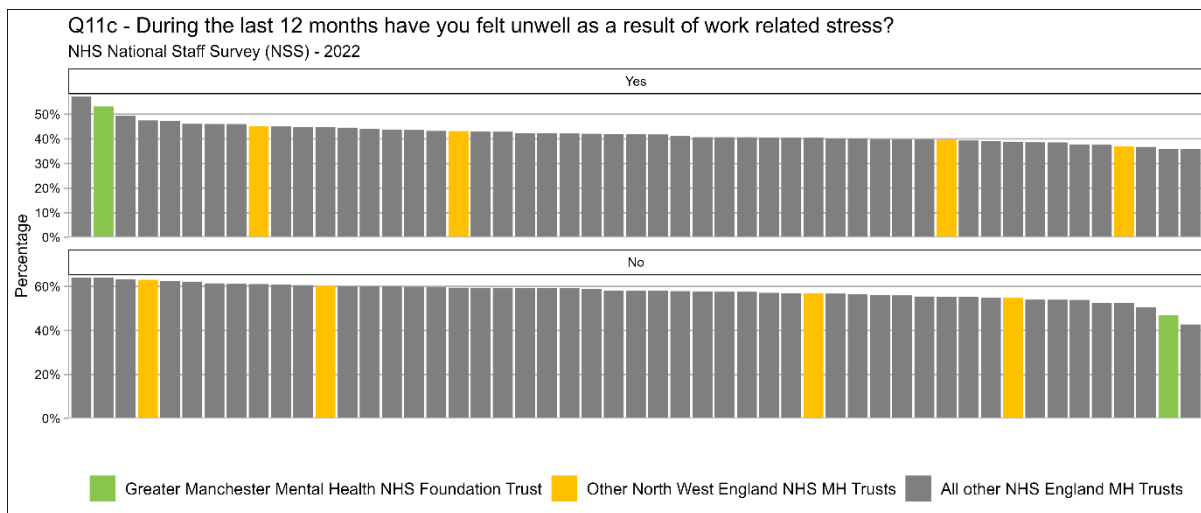
8. During the last 12 months have you felt unwell as a result of work-related stress? (Internal benchmarking)

In 2022, Forensic Services averaged 72% of staff answering yes when asked if they have felt unwell as a result of work-related stress in the last 12 months. Compared with all other GMMH services, Forensic Services would have the fifth highest percentage (out of 60 services), with the percentage being 22% higher than in 2021.

In 2022, Forensic Services had 9% more than the inpatient services average and 19% more than the GMMH average who answered yes to this question. Women's Blended Service had a large 85% of staff answer yes, as opposed to Medium and Low Secure services, where 70% of staff answered yes.

Q11c During the last 12 months have you felt unwell as a result of work related stress?
NHS National Staff Survey (NSS) - 2022 (Locality 3)

Legend:
- 437 S6 Medium and Low Secure Forensic In-Patient
- Other inpatient services
- Organisation Overall
- 437 S6 Womens Blended Service
- All other services

*Services with a responce rate less than 10 are exluded.
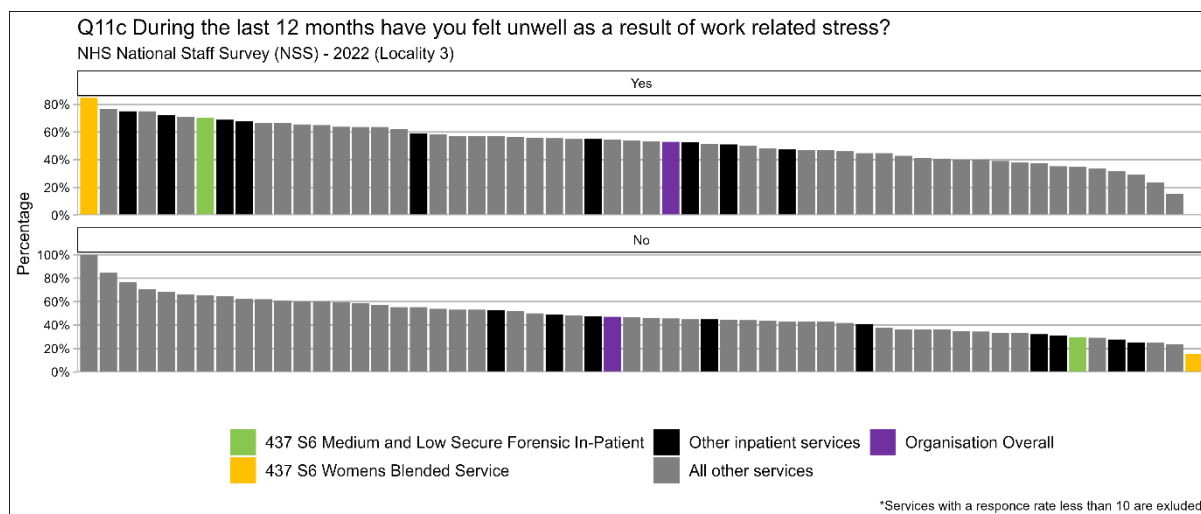
9. In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users? (Trust level)

In 2022, GMMH had 36% of staff say that they have seen errors, near misses or harmful incidents which could have harmed staff or service users over the last month. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

In 2022, GMMH had 10% more than the Northwest average and 10% more than the national average saying they have seen errors, near misses or harmful incidents which could have harmed staff or service users over the last month.
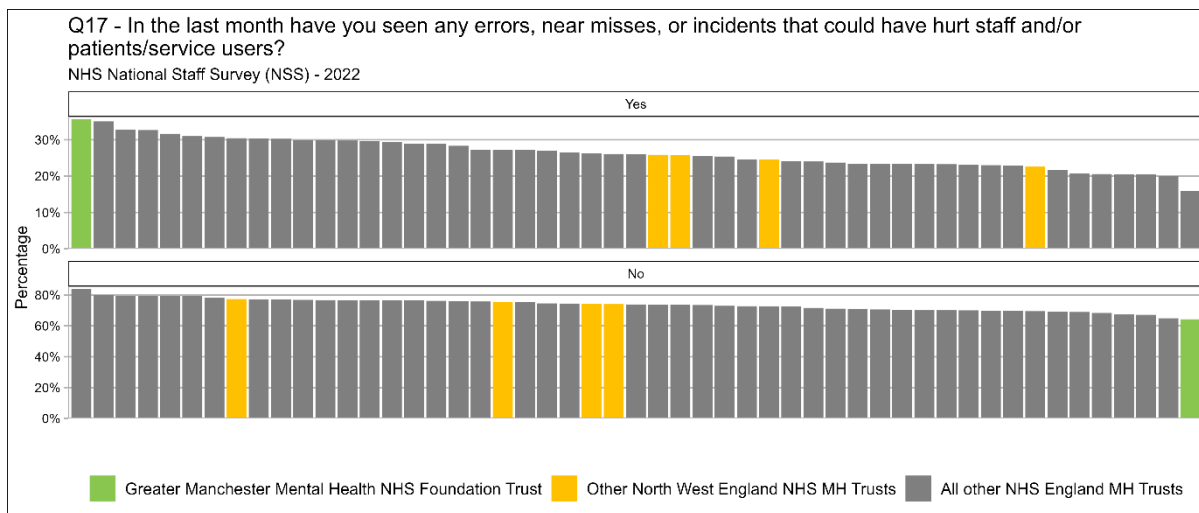
10. In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users? (Internal benchmarking)

In 2022, Forensic Services averaged a high percentage of 68% of staff answering yes when asked if they have seen any errors, near misses, or potentially harmful incidents in the last month. Compared with all other GMMH services, Forensic services had the fourth highest percentage (out of 60 services).

In 2022, Forensic Services had 12% more than the inpatient services average and 33% more than the GMMH average answer yes to the question. In Women's Blended Service 75% of the staff answered yes to the question, whereas for Medium and Low Secure services 67% of the staff answered yes.


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11. My organisation treats staff who are involved in an error, near miss or incident fairly. (Trust level)

In 2022, 13% of staff disagree or strongly disagree that GMMH treats staff who are involved in an error, near miss or incident fairly. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

In 2022, GMMH had 5% more than the Northwest average and 6% more than the national average either disagree or strongly disagree that GMMH treats staff who are involved in an error, near miss or incident fairly.

In 2022, GMMH had 37% of staff agree or strongly agree that GMMH treats staff who are involved in an error, near miss or incident fairly (the third lowest when compared to all other NHS England mental health trusts) and 50% remained neutral (answered either "neither agree nor disagree" or "don't know").
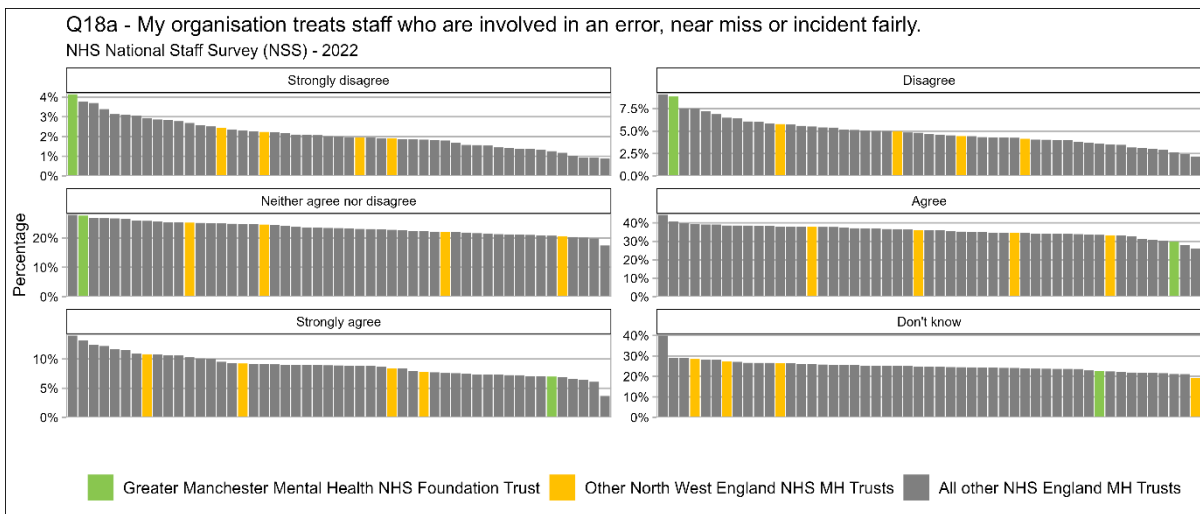
12. My organisation treats staff who are involved in an error, near miss or incident fairly. (internal benchmarking)

In 2022, Forensic Services had a high average of 34% of staff disagreeing that their organisation treats staff fairly who are involved in an error, near miss or incident. Compared with all other GMMH services, Forensic Services had the third highest percentage (out of 60 services).

In 2022, Forensic Services had 15% more than the inpatient services average and 21% more than the GMMH average disagree with the statement. Medium and Low Secure services had 36% of staff disagree with the statement, as opposed to 23% of staff in the Women's Blended Service disagreeing.
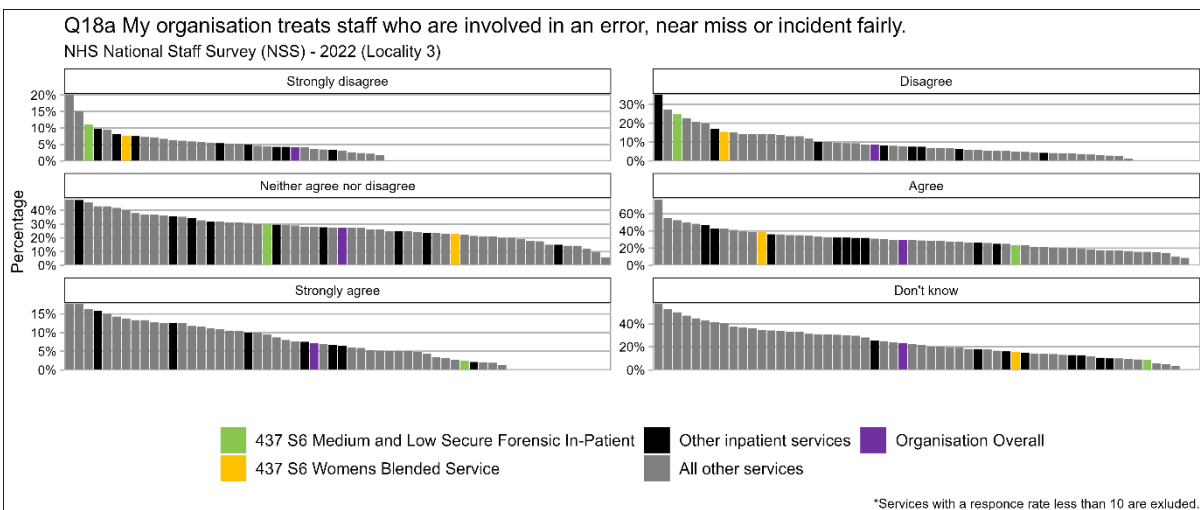
13. My organisation encourages us to report errors, near misses or incidents.

In 2022, 7% of staff disagree or strongly disagree that GMMH encourages staff to report errors, near misses or incidents. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

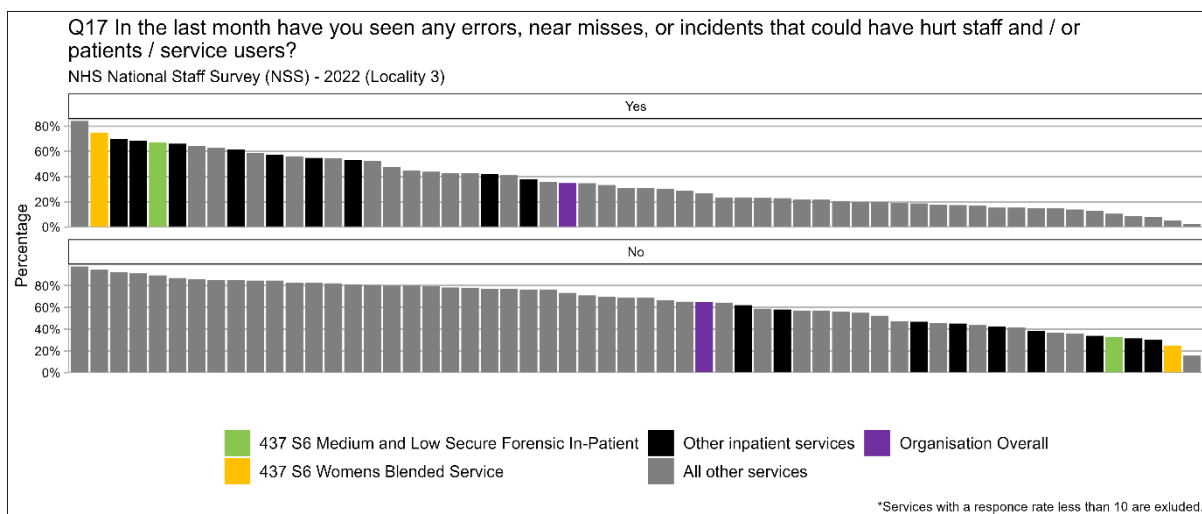In 2022, GMMH had 3% more than the Northwest average and 4% more than the national average either disagree or strongly disagree that GMMH encourages staff to report errors, near misses or incidents.

In 2022, GMMH had 76% of staff agree or strongly agree that GMMH encourages staff to report errors, near misses or incidents (second lowest when compared to all other NHS England mental health trusts) and 16% remained neutral (answered either "neither agree nor disagree" or "don't know").
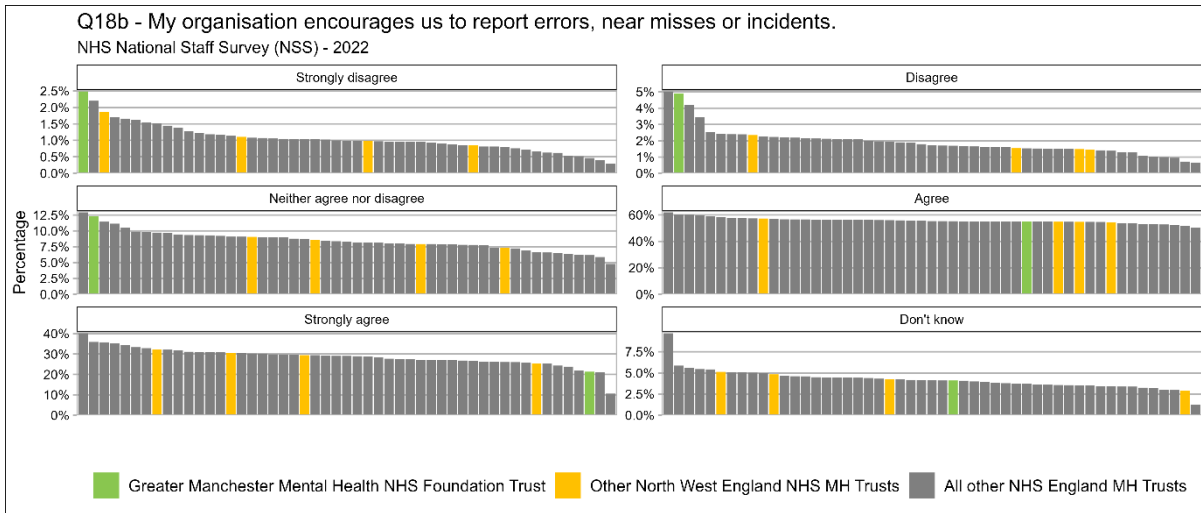
14. My organisation encourages us to report errors, near misses or incidents. (Internal benchmarking)

In 2022, Forensic Services had a high average of 30% of staff disagreeing that their organisation encourages them to report errors, near misses or incidents. Compared with all other GMMH services, Forensic Services had the highest percentage (out of 60 services).

In 2022, Forensic Services had 19% more than the inpatient services average and 23% more than the GMMH average disagree with the statement. Medium and Low Secure services had 32% of staff disagree with the statement, as opposed to 15% of staff in the Women's Blended Service disagreeing.
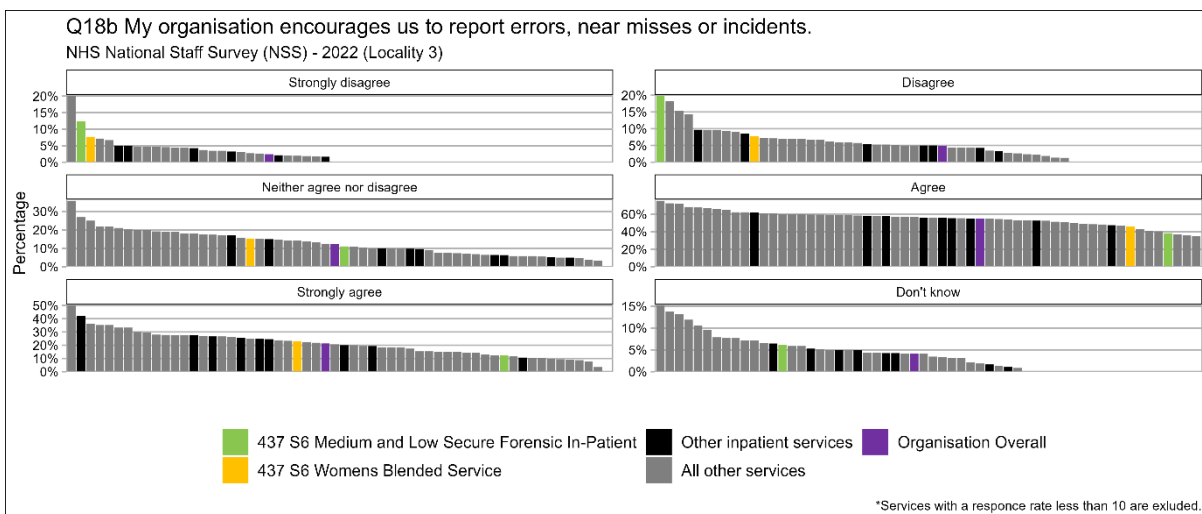
15. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.

In 2022, 13% of staff disagree or strongly disagree that GMMH takes action to ensure errors, near misses or incidents do not reoccur. This is the highest percentage when compared with all other NHS England mental health trusts. Note that this question was not asked in 2021.

In 2022, GMMH had 6% more than the Northwest average and 7% more than the national average either disagree or strongly disagree that GMMH takes action to ensure errors, near misses or incidents do not reoccur.

In 2022, GMMH had 49% of staff agree or strongly agree that GMMH takes action to ensure errors, near misses or incidents do not reoccur (third lowest when compared to all other NHS England mental health trusts) and 38% remained neutral (answered either "neither agree nor disagree" or "don't know").

Q18c - When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again
NHS National Staff Survey (NSS) - 2022

Legend: Greater Manchester Mental Health NHS Foundation Trust | Other North West England NHS MH Trusts | All other NHS England MH Trusts

16. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again. (Internal benchmarking)

In 2022, Forensic Services had a high average of 35% of staff disagreeing that their organisation takes action to ensure errors, near misses and incidents aren't repeated. Compared with all other GMMH services, Forensic Services had the second highest percentage (out of 60 services).

In 2022, Forensic Services had 16% more than the inpatient services average and 22% more than the GMMH average disagree with the statement. There was no notable difference between Medium and Low Secure and Women's Blended services.

Q18c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.
NHS National Staff Survey (NSS) - 2022 (Locality 3)

Legend: 437 S6 Medium and Low Secure Forensic In-Patient | Other inpatient services | Organisation Overall | 437 S6 Womens Blended Service | All other services

*Services with a responce rate less than 10 are exluded.

17. Care of patients/service users is my organisation's top priority.

In 2022, 18% of staff disagree or strongly disagree that the care of service users is GMMH's top priority. This is the second highest percentage when compared with all other NHS England mental health trusts and is 6% higher than in 2021 (where GMMH had the fourth highest percentage).

In 2022, GMMH had 8% more than the Northwest average and 11% more than the national average either disagree or strongly disagree that the care of service users is GMMH's top priority.

In 2022, GMMH had 61% of staff agree or strongly agree that the care of service users is GMMH's top priority and 21% neither agree nor disagree.
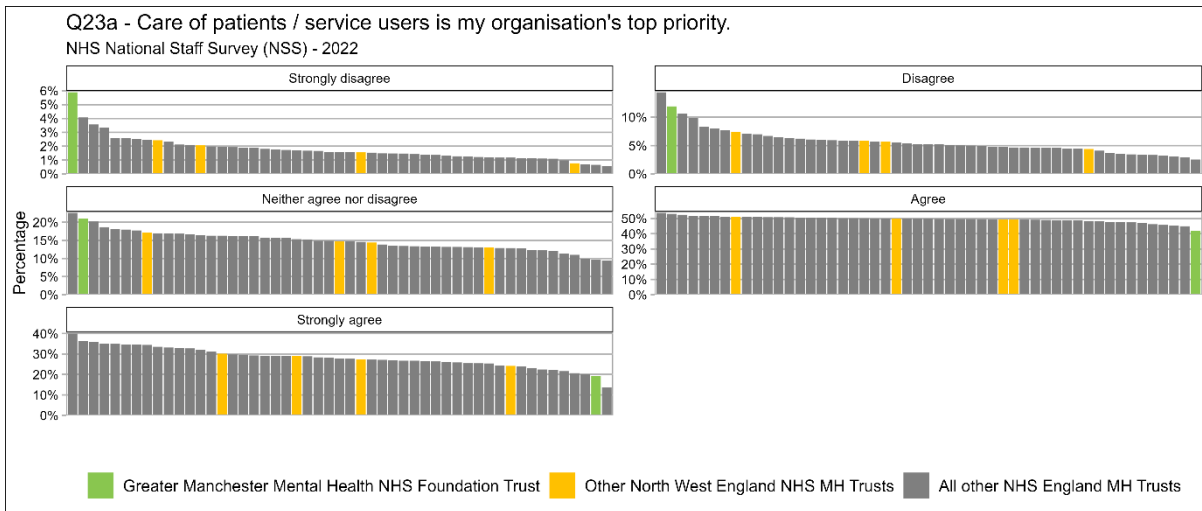
18. Care of patients/service users is my organisation's top priority. (Internal benchmarking)

In 2022, Forensic Services had a high 31% of staff disagreeing that the care of service users is the organisation's top priority. Compared with all other GMMH services, Forensic Services had the fifth highest percentage (out of 60 services), with the percentage being 18% higher than in 2021.

In 2022, Forensic Services had 12% more than the inpatient services average and 13% more than the GMMH average disagree with the statement. Medium and Low Secure services had 32% of staff disagree with the statement, as opposed to 23% of staff in the Women's Blended Service disagreeing.
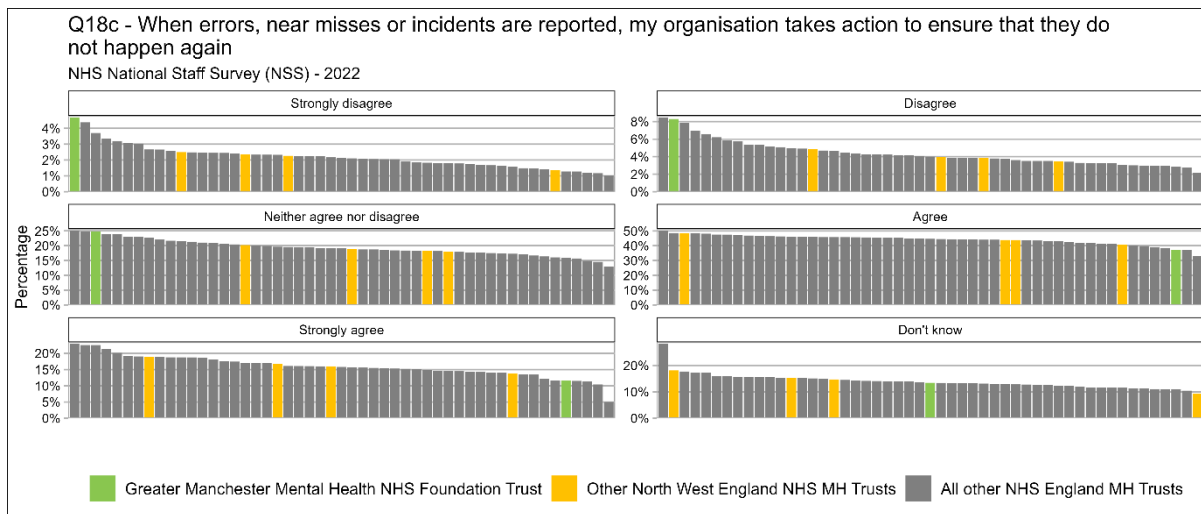

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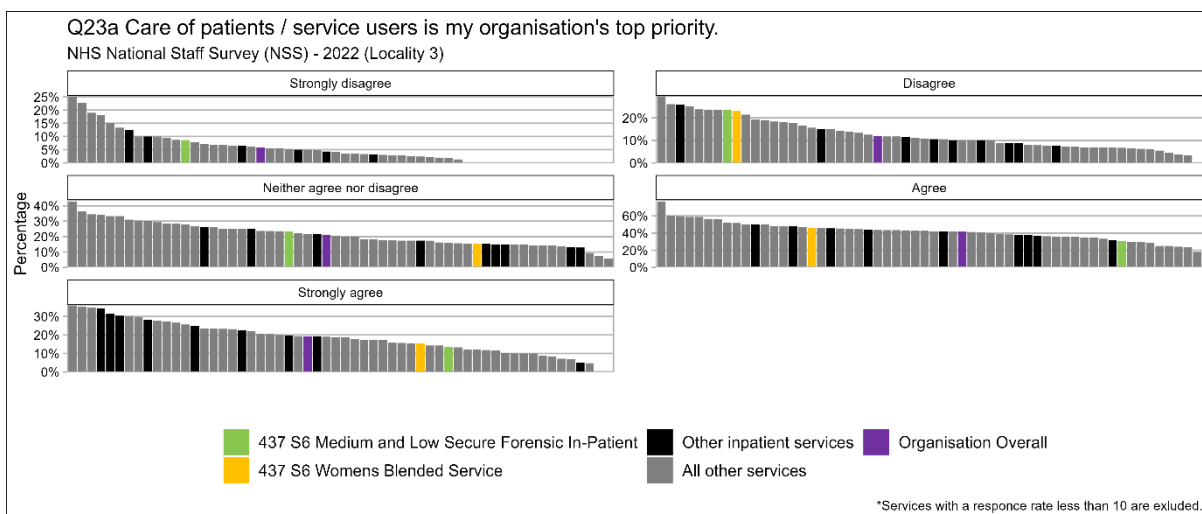
19. My organisation acts on concerns raised by patients/service users. (Internal benchmarking)

In 2022, Forensic Services had a high 34% of staff disagreeing that their organisation acts on service user concerns. Compared with all other GMMH services, Forensic Services had the third highest percentage (out of 60 services), with the percentage being 27% higher than in 2021.

In 2022, Forensic Services had 17% more than the inpatient services average and 19% more than the GMMH average disagree with the statement. Medium and Low Secure services had 36% of staff disagree with the statement, as opposed to 23% of staff in the Women's Blended Service disagreeing.

Q23b My organisation acts on concerns raised by patients / service users.
NHS National Staff Survey (NSS) - 2022 (Locality 3)

437 S6 Medium and Low Secure Forensic In-Patient
437 S6 Womens Blended Service
Other inpatient services
All other services
Organisation Overall

*Services with a responce rate less than 10 are exluded.
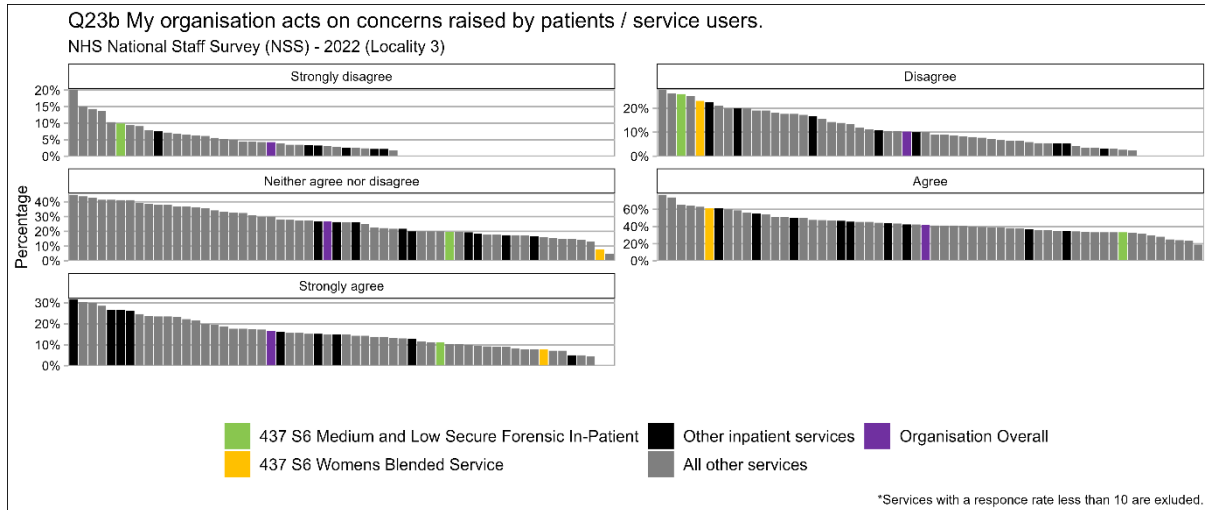
Appendix 3 – Case note audit: key analysis

Introduction

In July 2023, the review team undertook a case note audit using a randomised sample of 20 patient records on the Edenfield site. The following wards were in scope: Borrowdale, Derwent, Hayeswater, Dovedale, Eskdale, Ferndale, Newland/Fast, Silverdale and Ullswater.

Method

The audit focused on the last six months of care. The balance of male/female patients included in the audit was 50/50. The proforma was piloted with two sets of case notes at the outset of the audit, with minor revisions required subsequently made by the auditors. The auditors were supported to navigate the electronic patient record system throughout their work by a clinician from Edenfield.

For each patient we reviewed their relevant care plans (mental health, physical health, relationships, risk (and problem behaviours), and others as needed), their progress notes, and other parts of the Patient Record Information System as required to find specific information. If we could not find something after 15 minutes of looking, we stopped.

Case notes were scored as follows, but with comments added to explain these scores where necessary.

0 – no omissions

1 – occasional omissions

2 – several omissions/deviations from good practice

3 – regular omissions/deviations from good practice

4 – significant omissions/deviations from good practice

5 – must be referred as a significant cause of concern

Audit proforma

This proforma was designed by the review team, using their collective knowledge and experience, and with reference to the findings made by BBC Panorama.

The audit areas and questions were:

1) **Quality of the record**
    a. Entries are legible and chronological.
    b. Key decisions are documented by suitably qualified staff as per the Trust policy.
    c. Entries are all signed and dated. The person making the entry is clearly identifiable.
    d. There is no evidence of retrospective or 'bulk' entries being made.
    e. The patient is described in a professional way which is free of opinion.

2) **Individualised care**
    a. There is a clear and up-to-date trauma-informed, asset-based care plan.
    b. The care plan is based upon a thorough and co-produced assessment of need.
    c. There is a clear primary diagnosis and a clear indication of secondary and co-morbid factors (including any physical health needs).
    d. There is an up-to-date and good summary of the main points that need to be considered when supporting the patient.
    e. It is clear in the case notes who in the family is to be contacted and how they would like to be contacted (assuming that individuals have consented to this).
    f. There is an up-to-date approved visitors list in the notes.

g. There is clear evidence of family engagement/views of family (and this is noted as 'third-party').

h. There is evidence of families being kept informed when significant changes to care happen (assuming that individuals have consented to this), i.e., move to seclusion, assaults, ligatures, etc.

i. There is evidence that a carer's assessment has been offered.

j. Where a carer's assessment was accepted, there is evidence that one was completed.

3) Risk assessment

a. An up-to-date risk assessment is in place.

b. The risk plan is regularly reviewed and reviewed in line with the Trust policy.

c. There is an up-to-date crisis plan in place.

4) Least restrictive practice

a. Where restrictive practice is used (including seclusion, enhanced observations), there is evidence that this has been regularly reviewed as per Trust policy.

b. Individuals have frequent access to outside space and activities.

c. There is an intervention/ positive behaviour support (PBS) plan in place.

d. Is there evidence of staff following the PBS plan?

5) Law

a. The legal status of the individual is clearly reported, and their capacity is documented in line with the Mental Capacity Act (MCA).

b. There is evidence that the patient has been informed of any changes to their status under the Mental Health Act (MHA). as per Trust policy.

c. Treatment is given in line with the MHA.

d. There is clear evidence of referral to a second opinion appointed doctor (SOAD).

e. There is evidence of regular mental capacity tests being undertaken.

f. The leave status is recorded and understandable as per Trust policy.

g. There is identification of clear escalations to other agents around the patient, where needs are identified, for example, safeguarding, an independent mental health advocate.

Summary findings

1. Quality of the record	
a) Entries are legible and chronological.	No major concerns identified.
b) Key decisions are documented by suitably qualified staff as per the Trust policy.	Standard typically met; there were more entries by qualified staff than anticipated. Patients were frequently described as "*settled*" without any attempt to describe this.
c) Entries are all signed and dated. The person making the entry is clearly identifiable.	A significant minority were not signed.
d) There is no evidence of retrospective or 'bulk' entries being made.	We only found one clearly retrospective entry. No evidence of bulk entries although some care plan entries were very generic.
e) The patient is described in a professional way which is free of opinion.	We found no evidence of unprofessional or judgemental descriptions of patients.

2. Individualised care	
a) There is a clear and up-to-date trauma-informed, asset-based care plan.	Care plans were very variable in nature; however, very few were in any way trauma-informed. There are no prompts within the care plan documented used for trauma-informed information. Where trauma history information was captured (within risk assessments for example) this was not picked up within the mental health care plan. Two segregation plans we saw were trauma informed.
b) The care plan is based upon a thorough and co-produced assessment of need.	Variable: there were good and poor examples found. Most appeared to be co-produced with lots of "I" statements although some of these were written in professional language which most patients would not normally use such as "*I hope to engage in more therapeutic relationships with my peers*". Some plans were individualised and gave a clear picture of the patient as a person, whereas others were so general they could have applied to any patients on the ward. Where patients had declined to be involved in developing the plan or having a copy this was generally stated in the notes.
c) There is a clear primary diagnosis and a clear indication of secondary and co-morbid factors (including any physical health needs).	Primary diagnosis usually clear and confirmed within current period. Very few had secondary diagnosis recorded. The physical health care plan prompted information capture on this, although input was variable. Some physical care plans seemed to include information which should have been stored elsewhere, e.g., one patient's diabetes care plan included a ligature plan.
d) There is an up-to-date and good summary of the main points that need to be considered when supporting the patient.	Variable and stored inconsistently in different parts of the record.
e) It is clear in the case notes who in the family is to be contacted and how they would like to be contacted (assuming that individuals have consented to this).	We could not find this quickly, or at all in some cases.
f) There is an up-to-date approved visitors list in the notes.	All patients had a list with contact details, although some were very dated and may not have been recently reviewed.
g) There is clear evidence of family engagement/views of family (and this is noted as 'third-party').	This was poorly collected. The family's voice was often not there at all. The family voice was weak in most plans. For example, in one record a patient had assaulted a family member, and the plan was for the patient to return to live with other members of the family. This was stated several times in the notes, but without indication of what the family members' views were of this expectation.
h) There is evidence of families being kept informed when significant changes to care happen (assuming that individuals have consented to this), i.e., move to seclusion, assaults, ligatures, etc.	This was difficult to find. We did not find any good examples of this being undertaken.

i)	There is evidence that a carer's assessment has been offered.	This section was often not completed.
j)	Where a carer's assessment was accepted, there is evidence that one was completed.	Few examples found.

<table>
<tr><td colspan="3">3. Risk assessment</td></tr>
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a)	An up-to-date risk assessment is in place.	All had an up-to-date plan, but the content and quality were variable.
		Few were trauma informed. Many contained generic statements rather than ones which appeared to be specific to the individual patient.
b)	The risk plan is regularly reviewed and reviewed in line with the Trust policy.	On first review, risk assessments appeared to be in date. However, on closer inspection, risk assessments frequently contained information, which was likely to be out of date, for example, referring to wards which the patient was no longer on.
c)	There is an up-to-date crisis plan in place.	We did not find any evidence of individual crisis plans labelled on the system. The ward manager working with us confirmed that they did not have such documents.
		Some elements of what you might expect to find in a crisis plan were contained within a number of documents such as the risk plan or segregation plan.

4. Least restrictive practice

a)	Where restrictive practice is used (including seclusion, enhanced observations), there is evidence that this has been regularly reviewed as per Trust policy.	Yes – generally, evidence of review found.
b)	Individuals have frequent access to outside space and activities.	This was apparent in the progress notes.
		There were several entries documenting that patients had attended activities, but with little reference to the impact of these activities on the patient's recovery and wellbeing.
c)	There is an intervention/PBS plan in place	We only found one PBS plan within the notes reviewed, although some elements of this were included within other parts of the record.
d)	Is there evidence of staff following the PBS plan?	N/A

5. Law

a)	The legal status of the individual is clearly reported, and their capacity is documented in line with the MCA.	Yes for legal status; less clearly for MCA status. The location of this information was inconsistent, such that it was hard to find and sometimes unclear.
b)	There is evidence that the patient has been informed of any changes to their status under the MHA, as per Trust policy.	There was evidence that the vast majority of patients had had their rights and status under the MHA read to them within the period under review, and with signed documents on the system.

c)	Treatment is given in line with the MHA.	Yes, as far as we could tell given the time available. There may be elements of this which require more specific audit.
d)	There is clear evidence of referral to a SOAD.	Yes, as far as we could tell, although the location of relevant information was inconsistent in the record and required significant effort to find.
e)	There is evidence of regular mental capacity tests being undertaken.	See above.
f)	The leave status is recorded and understandable as per Trust policy.	This was typically done well.
g)	There is identification of clear escalations to other agents around the patient, where needs are identified, for example, safeguarding, an independent mental health advocate.	Information was frequently difficult to locate, particularly safeguarding information which required some searching around the system.

1 – Quality of the record

1. Quality of the record

Scores are calculated such that: 0 = no omissions, 1 = occasional omissions, 2 = several omissions / deviations from good practice, 3 = regular omissions / deviations from good practice, 4 = significant omissions / deviations from good practice, and 5 = must be referred as a significant cause of concern

2 – Individualised care (a)

2. Individualised care - Part 1

a) There is a clear and up to date trauma informed, asset-based care plan.

b) The care plan is based upon a thorough and co-produced assessment of need.

c) There is a clear primary diagnosis and a clear indication of secondary and co-morbid factors (including any physical health needs).

d) There is an up to date and good summary of the main points that need to be considered when supporting the patient.

e) It is clear in the case notes who in the family is to be contacted and how they would like to be contacted (assuming that individuals have consented to this).

Scores are calculated such that: 0 = no omissions, 1 = occasional omissions, 2 = several omissions / deviations from good practice, 3 = regular omissions / deviations from good practice, 4 = significant omissions / deviations from good practice, and 5 = must be referred as a significant cause of concern

2 – Individualised care (b)

2. Individualised care - Part 2

f) There is an up-to-date approved visitors list in the notes.

g) There is clear evidence of family engagement / views of family (and this is noted as 'third-party').

h) There is evidence of families being kept informed when significant changes to care happen (assuming that individuals have consented to this) i.e. move to seclusion/ assaults/ ligatures etc.

i) There is evidence that a carer's assessment has been offered.

j) Where a carers assessment was accepted there is evidence that one was completed.

Scores are calculated such that: 0 = no omissions, 1 = occasional omissions, 2 = several omissions / deviations from good practice, 3 = regular omissions / deviations from good practice, 4 = significant omissions / deviations from good practice, and 5 = must be referred as a significant cause of concern

3 – Risk assessment

3. Risk assessment

a) An up-to-date risk assessment is in place.

b) The risk plan is regularly reviewed and reviewed in line with the Trust policy.

c) There is an up-to-date crisis plan in place.

Scores are calculated such that: 0 = no omissions, 1 = occasional omissions, 2 = several omissions / deviations from good practice,
3 = regular omissions / deviations from good practice, 4 = significant omissions / deviations from good practice, and
5 = must be referred as a significant cause of concern

4 – Least restrictive practice

4. Least restrictive practice

a) Where restrictive practice is used (including seclusion, enhanced observations), there is evidence that this has been regularly reviewed as per Trust policy.

b) Individuals have frequent access to outside space and activities.

c) There is an intervention / PBS plan in place

d) Is there evidence of staff following the PBS plan?

Scores are calculated such that: 0 = no omissions, 1 = occasional omissions, 2 = several omissions / deviations from good practice,
3 = regular omissions / deviations from good practice, 4 = significant omissions / deviations from good practice, and
5 = must be referred as a significant cause of concern

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5 – Law

5. Law - Part 1

a) The legal status of the individual is clearly reported.

b) Their capacity is documented in line with the MCA.

c) There is evidence that the service user has been informed of their rights under the Mental Health Act in the last six months.

d) Treatment is given in line with the MHA.
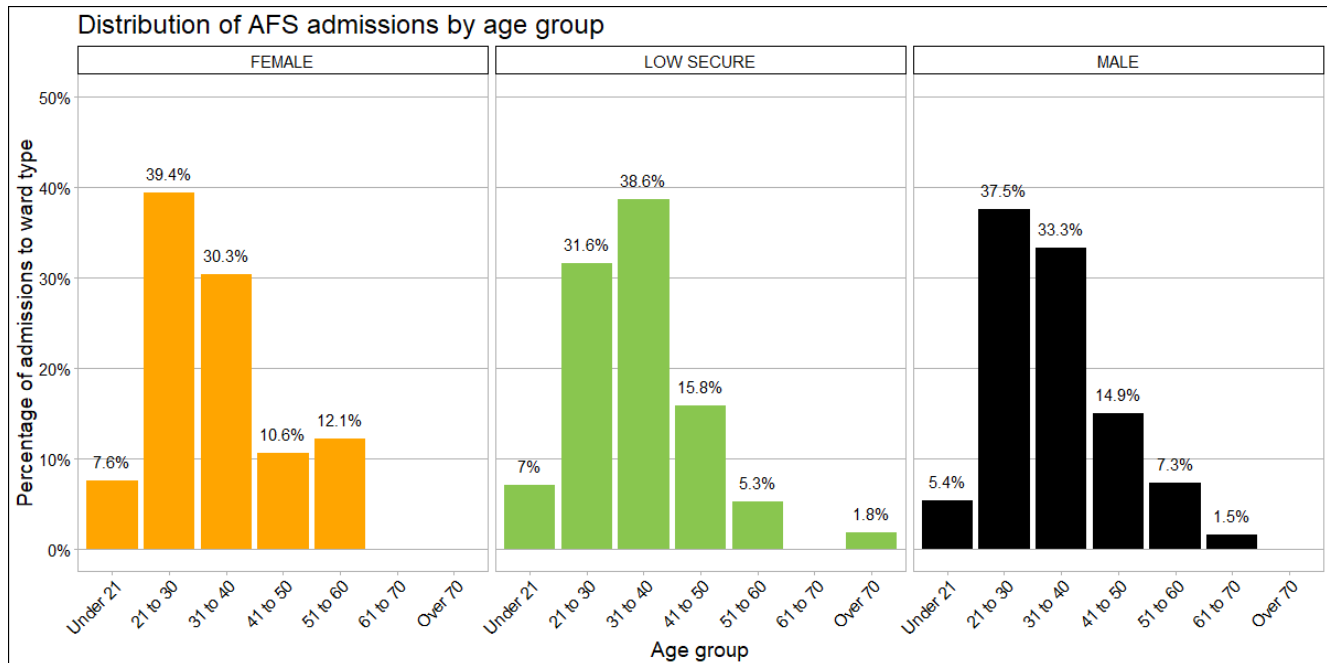
Scores are calculated such that: 0 = no omissions, 1 = occasional omissions, 2 = several omissions / deviations from good practice, 3 = regular omissions / deviations from good practice, 4 = significant omissions / deviations from good practice, and 5 = must be referred as a significant cause of concern

Appendix 4 – Contextual analysis

The population of Edenfield

The age distributions are relatively similar for each service, with around 70% of all admissions aged between 21 and 40. The average age on admission was 33.3 for female wards, 34.2 for male wards and 34.5 for low secure wards.
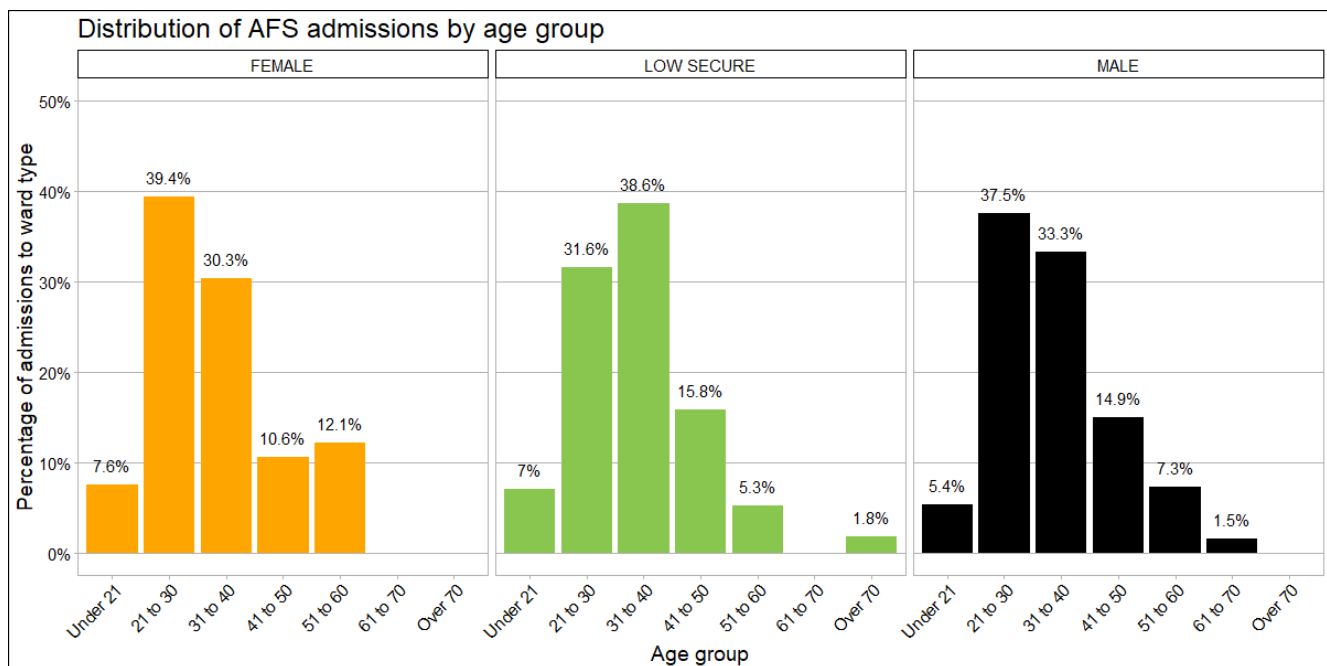

The age distributions are relatively similar for each service, with around 70% of all admissions aged between 21 and 40. The average age on admission was 33.3 for female wards, 34.2 for male wards and 34.5 for low secure wards.

Ethnicity distribution at Edenfield by AFS service, for patients occupying a bed between April 2020 to March 2023

Distribution of AFS admissions by ethnic group
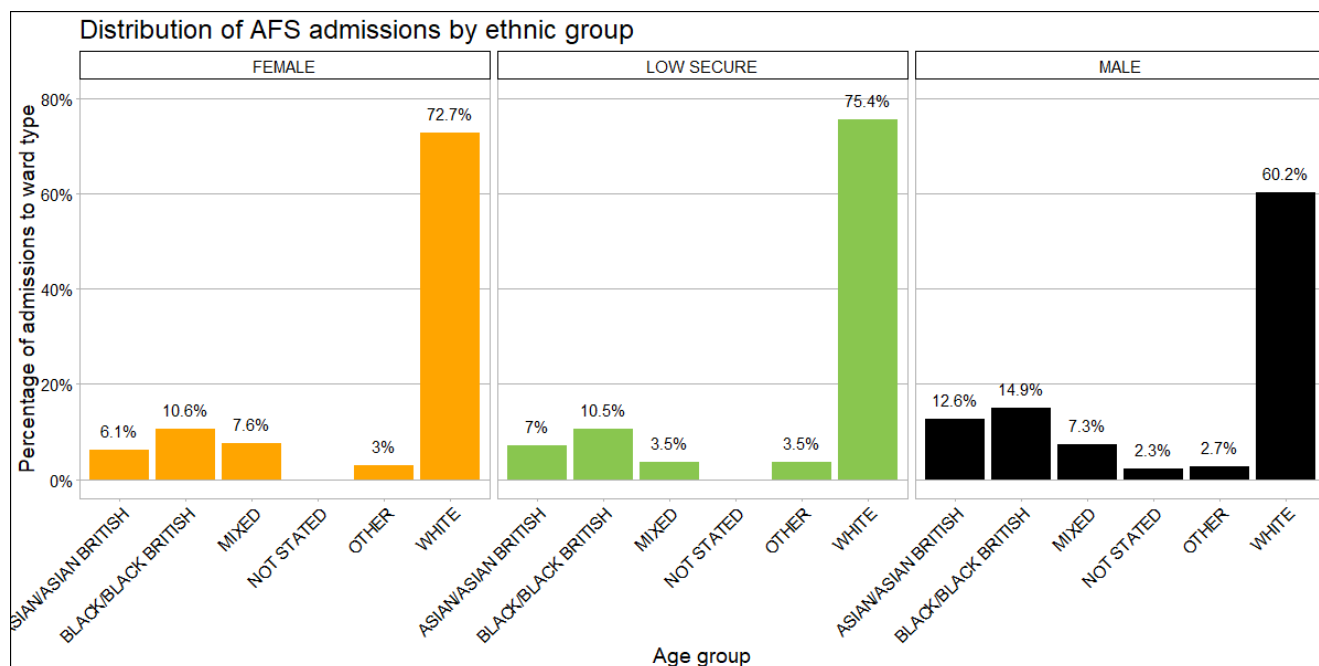
Source of admission to Edenfield AFS services, for patients occupying a bed between April 2020 to March 2023

Source of admission	FEMALE (n = 66)	LOW SECURE (n= 57)	MALE (n = 261)
Local authority residential accommodation i.e. where care is provided	2%	2%	1%
NHS other hospital provider: ward for general patients or A&E department	6%	12%	4%
NHS other hospital provider: ward for patients who are mentally ill or have learning disabilities	27%	21%	13%
NHS other Hospital Provider - high security psychiatric	6%	2%	10%
Non-NHS (other than local authority) run care home	2%	2%	1%
Non-NHS run hospital	26%	11%	3%
Not applicable	0%	0%	1%
Not known	2%	0%	2%
Penal establishment, court or police station / police custody suite	23%	37%	56%
Temporary place of residence	0%	2%	2%
Usual place of residence	8%	12%	7%

Discharge destination from Edenfield AFS services, for patients occupying a bed between April 2020 to March 2023

| Discharge Destination	FEMALE (n = 51)	LOW SECURE (n= 44)	MALE (n = 172)
Local Authority residential accommodation i.e. where care is provided	4%	0%	0%
NHS other hospital provider - high security psychiatric	2%	0%	9%
NHS other hospital provider - medium secure unit	14%	0%	4%
NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities	16%	23%	10%
NHS other hospital provider: ward for general patients or A&E department	0%	2%	1%
Non-NHS (other than Local Authority) run Care Home	16%	7%	3%
Non-NHS run hospital	16%	39%	17%
Non-NHS run hospital - medium secure unit	4%	2%	3%
Not Known	8%	2%	2%
Penal establishment, court or police station / police custody suite	10%	9%	28%
Temporary place of residence	2%	2%	6%
Usual place of residence	10%	14%	16%

Mental Health Act Status on admission to AFS services, for patients occupying a bed between April 2020 to March 2023

| Mental Health Act Status on admission	FEMALE (n = 66)	LOW SECURE (n= 57)	MALE (n = 261)
1983 MHA 47/49 LIFE LICENCE	0%	2%	2%
1983 MHA SECT 37/41 COND DISCH	2%	5%	0%
1983 MHA SECTION 2	9%	16%	14%
1983 MHA SECTION 3	38%	26%	13%
1983 MHA SECTION 36	0%	0%	0%
1983 MHA SECTION 37	8%	2%	0%
1983 MHA SECTION 37 NOTIONAL	3%	4%	2%
1983 MHA SECTION 37/41	6%	5%	7%
1983 MHA SECTION 37/41 RECALL	8%	0%	6%
1983 MHA SECTION 38	2%	4%	3%
1983 MHA SECTION 47	0%	2%	1%
1983 MHA SECTION 47/49	6%	16%	26%
1983 MHA SECTION 48/49	11%	7%	14%
1983 MHA SECTION 5(2)	0%	0%	1%
COMMUNITY TREATMENT ORDER	5%	5%	2%
CRIM PROCEDURE INSANITY ACT	2%	0%	0%
INFORMAL	2%	7%	6%
ON LEAVE TO GMMH	0%	0%	1%
UNKNOWN	2%	0%	0%

Restrictive practice

Positive and Proactive Care (Department of Health and Social Care, 2014) places an increasing focus on the use of preventive approaches and de-escalation for managing behaviour when patients are distressed. All restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need. The Mental Health Act Code of Practice 2015 states that "*Any restrictive interventions (e.g., restraint, seclusion and segregation) must be undertaken only in a manner that is compliant with human rights.*"
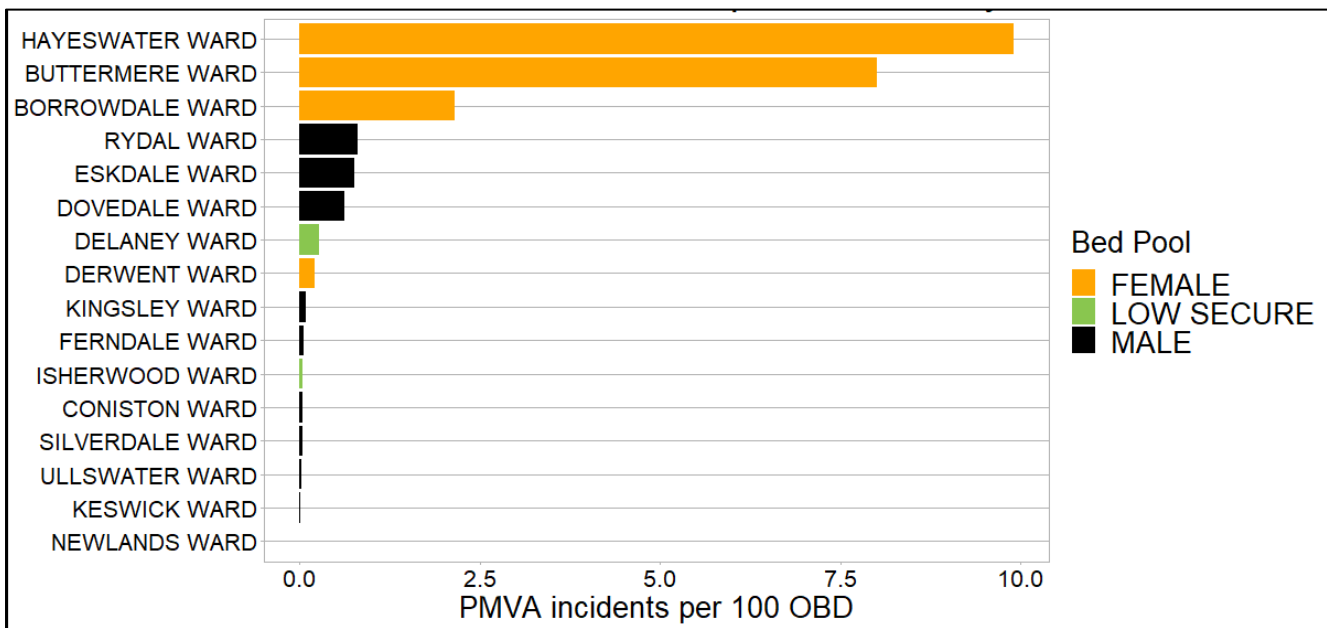
139

Seclusion incidents per 100 occupied bed days, by ward, at Edenfield, April 2020 to March 2023
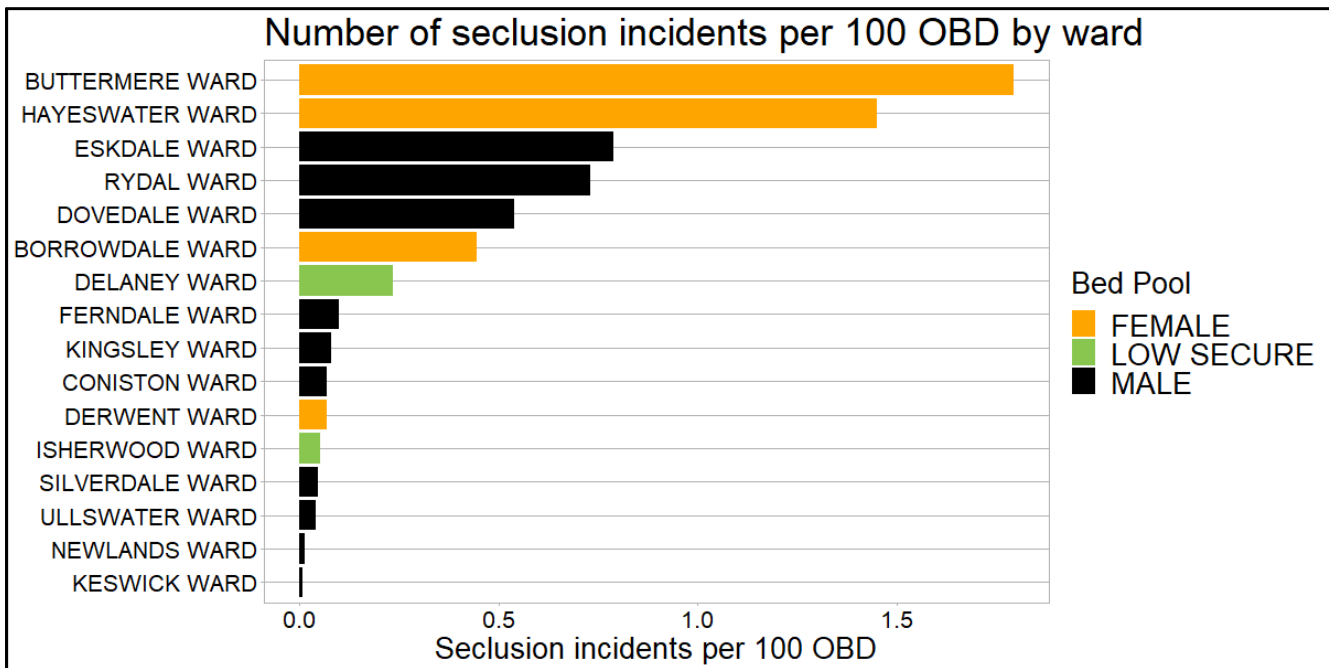
PMVA incidents per occupied bed day over time at Edenfield, April 2020 to March 2023
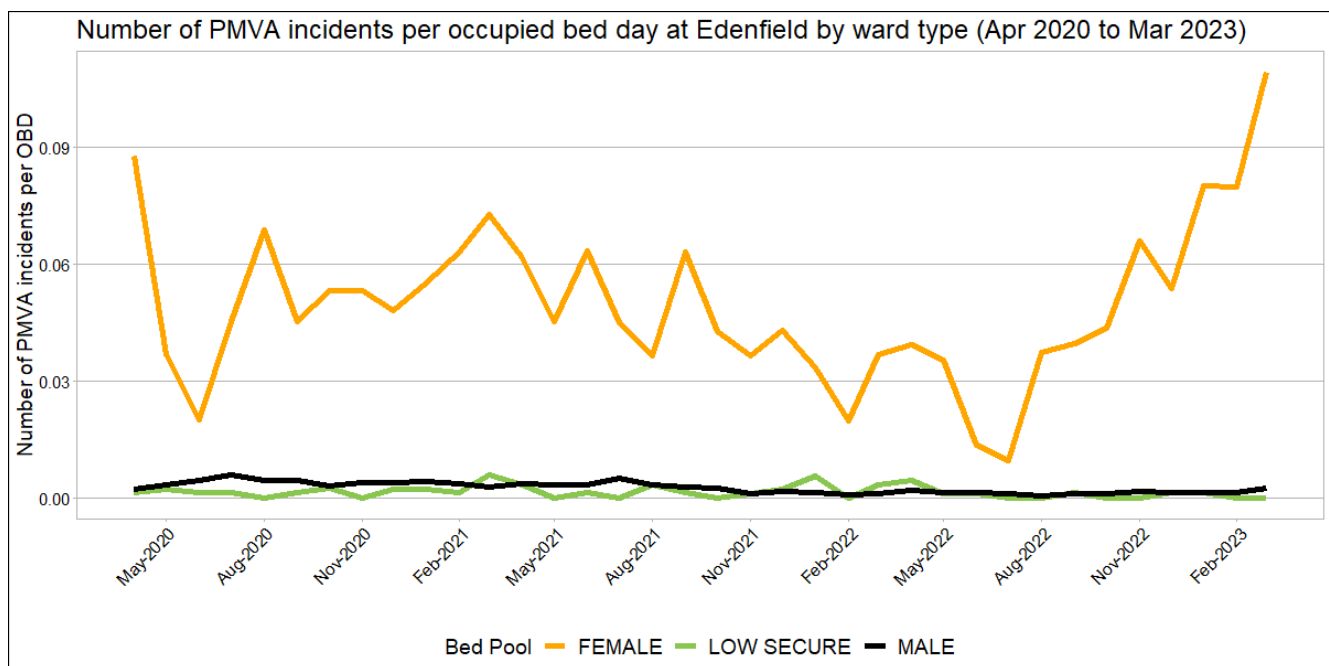
PMVA incidents per 100 occupied bed days, by ward, at Edenfield, April 2020 to March 2023

Monthly referral contacts from Edenfield to Bury Adult Safeguarding
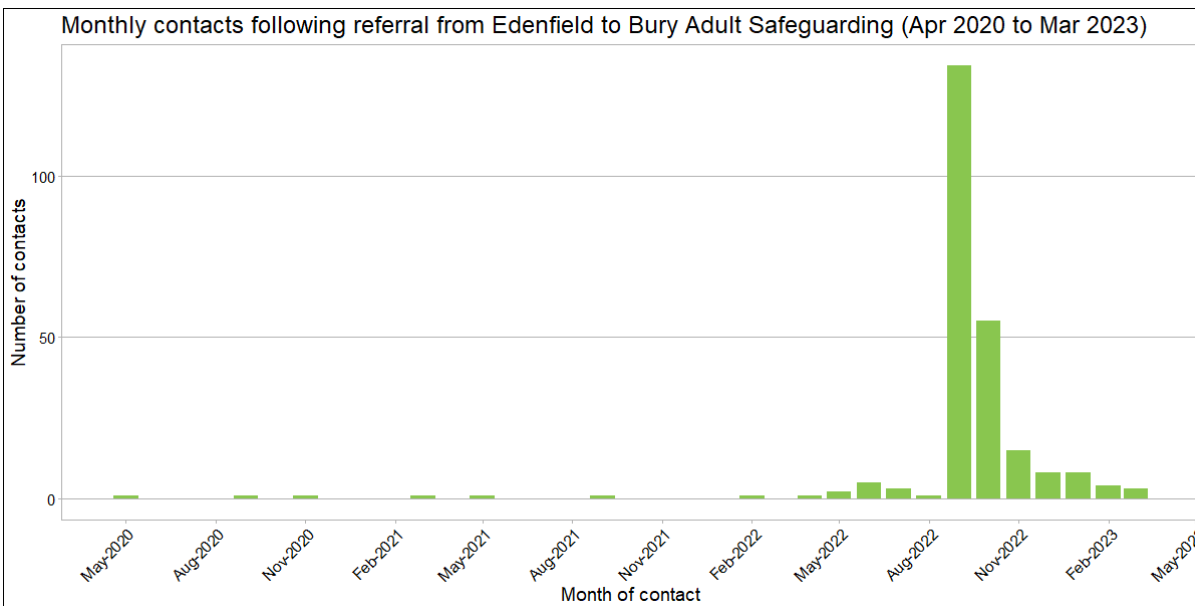
77% of all contacts appeared to take place in September and October 2022, with small volumes of activity prior to this. 54% of all contacts resulted in an outcome of proceeding the safeguarding enquiry, 37% were resolved at contact, while 9% had a blank outcome recorded.

Appendix 5 – Timeline of key events

Summary timeline

Detailed chronology

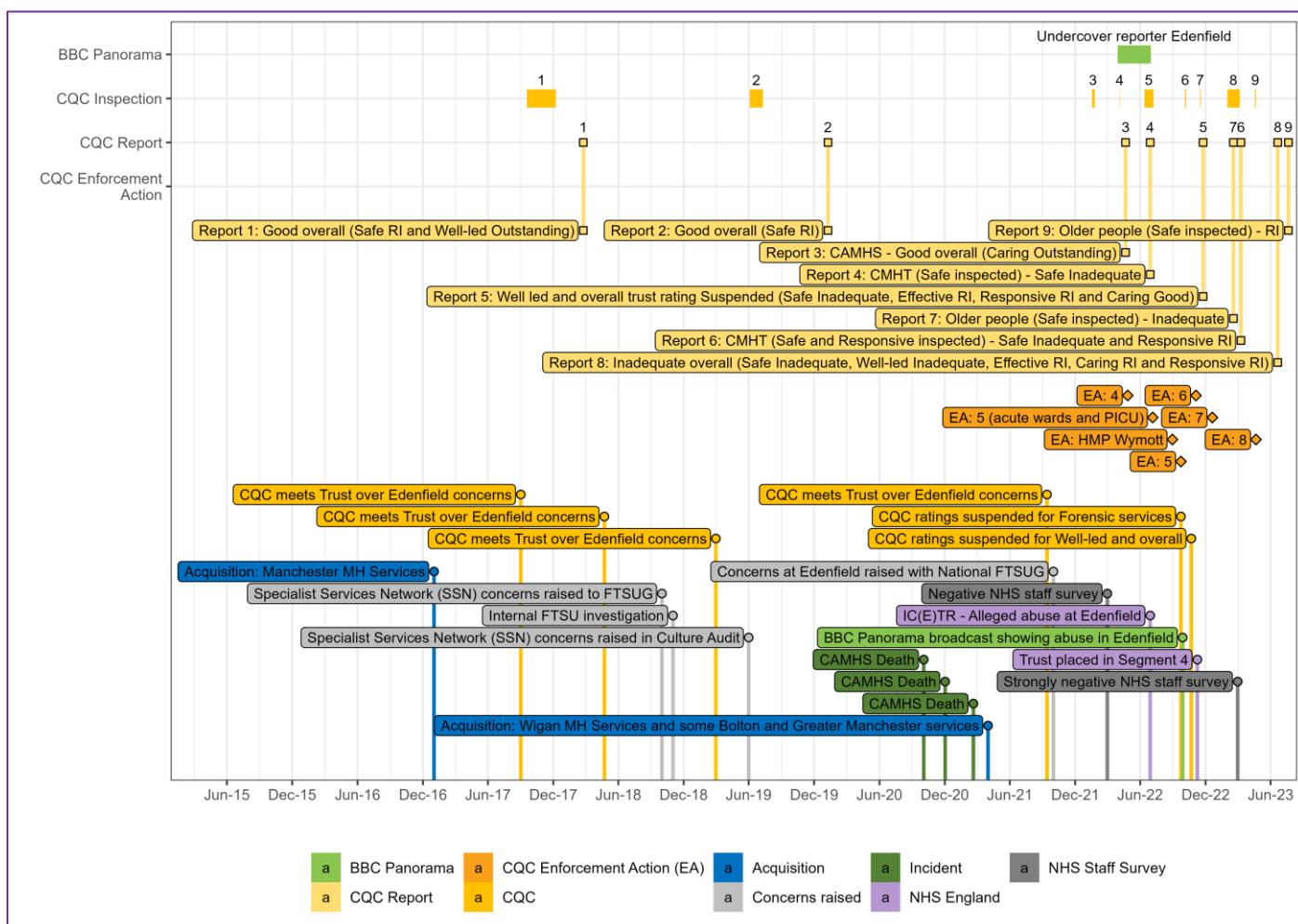| Date	Event
January 2017	Greater Manchester Mental Health NHS Foundation Trust was formed with the acquisition of Manchester Mental Health and Social Care Trust.
1 September 2017	Following an on-site Mental Health Act review visit of Keswick ward (Edenfield) concerns were raised by CQC with the trust about staffing levels on the ward in August 2017. Concerns were followed up with information requests to the Trust. The Inspector and Inspection Manager (IM) at that time attended an onsite meeting with managers from Edenfield on 01 September 2017.
September-December 2017	CQC inspection. Core services inspected were acute admission wards for working-age adults and psychiatric intensive care units (PICU), child and adolescent mental health wards, wards for older people, long-stay rehabilitation wards, substance misuse services and a well-led inspection of the Trust overall.

February 2018	CQC report published for the Trust: The Trust rating is Good overall. The Safe domain is rated Requires Improvement, Effective, Caring and Responsive domains are rated Good and Well-led domain was rated Outstanding.
April 2018	A new CEO is appointed.
23 April 2018	The CQC met with senior managers from the Edenfield Centre prior to a Trust engagement meeting with the Trust to discuss Edenfield regarding recent whistleblowing and patient complaints.
October 2018	Concern raised to FTSUG at the Trust regarding Specialist Services Network (SSN). This includes the Edenfield Centre. Concerns were that there were often not enough staff at Edenfield: staff covering multiple wards, there was a ban on using agency staff, a culture of not speaking up, staff were not reporting incidents and there was poor quality data.
November 2018	The Trust commissioned an internal FTSU investigation into concerns raised in October. A draft report was produced: '*In summary, the root cause of the staffing challenges within SSN is a significant shortfall in Registered Nurses. This needs to be quantified and a strategy put in place to ensure the wards can be staffed safely and with minimum Registered Nurse cover at all times. The root cause of why the concern was raised is lack of confidence in the current management team to address safety issues within the network. This requires a cultural shift and transparency in order that the extent of the challenges can be specified and addressed.*'
March 2019	CQC undertook enhanced engagement activities at Edenfield. This included a walk-round of some of the wards and two staff focus groups (ward managers and open staff group). This was in response to concerns being raised with CQC about staffing levels and the impact of these in early 2019. CQC gave feedback to the Trust about themes identified from the focus groups and areas the Trust might need to consider.
June 2019	Report completed of an external Organisational Behaviour Audit which was piloted in the Specialist Service Care Group, which included Forensic Services among others. It identified concerns in Forensic Services.
4 June – 10 July 2019	CQC inspection: Core services inspected: Acute admission wards for adults of working age and psychiatric intensive care units, forensic inpatients/secure wards, community-based mental health services for adults of working age and specialist community mental health services for children and young people. CQC also completed a well-led inspection of the overall Trust.
9 January 2020	CQC report published from June 2019 inspection: The Trust is rated as Good overall. The Safe domain is rated Requires improvement; Effective, Caring, Responsive and Well-led domains are rated as Good. Forensic services were rated Good overall: Safe domain was rated as Requires Improvement, Effective, Caring, Responsive and Well-led domains were rated Good. The CQC inspection was prompted partly in response to concerns raised to them anonymously by staff. These related to staffing levels, burnout, staff not feeling safe to raise concerns with managers, and that the local management response was inadequate. Inspectors visited 12 wards out of 18 wards in total. The report for forensic services notes that *'staff did not always make requests for cover through the on-call management system.'* The report also notes that the *'decisions to deploy staff to cover duties on different wards should be agreed through the on-call management system in place and take account of those staff who have disability passports and are not meant to be moved to cover other ward areas.*'

Q4 2019/2020	The Trust undertook a review of staffing levels at Edenfield using the Mental Health Optimal Staffing Tool (MHOST). The results of this exercise were not available. Management told the review team that it showed a clear staffing deficit on some wards. Consultants told the review team that they had been told by management that the service was overstaffed according to the tool.
3 October 2020	Death of a young person who was an inpatient on the Gardener Unit, a secure CAMHS service.
2 December 2020	Death of a young person who was an inpatient at Junction 17, a CAMHS service.
7 December 2020	CQC inspection: Acute wards for adults of working age and psychiatric intensive care units. Focused inspection at Park House.
December 2020	There were concerns raised with the CQC regarding the quality of care on Buttermere and Ferndale wards. This led to the CQC raising a safeguarding alert and arranging a meeting with the Trust to discuss the concerns.
11 February 2021	CQC inspection report published from December inspection: Safe rated Requires improvement, well-led not rated.
19 February 2021	Death of an inpatient on Griffin Ward at Junction 17, a CAMHS service.
1 April 2021	The Trust acquired Wigan mental health services, and a small number of Bolton and Greater Manchester-wide services.
July 2021	Ongoing whistleblowing from Edenfield staff to the CQC. The CQC shared their increasing and continued concerns about this with the Trust.
6 September 2021	CQC inspection: Acute wards for adults of working age and psychiatric intensive care units. Focused inspection of 8 wards.
13 September 2021	A virtual meeting took place between the CQC and the Trust to discuss concerns received by the CQC over the summer in respect of Edenfield. The Trust gave updates regarding Edenfield and actions that were being taken on the unit, including Quality Improvement projects that were due to start. The CQC agreed to receive updates as part of the regular engagement meetings with the Trust.
1 October 2021	Concerns were raised with NHS England national FTSUG about the Edenfield Centre. The concerns related to low levels of staff at the Edenfield Centre and staff being moved to provide cover. The NHS England guardian signposted the person to the Trust FTSUG and concerns were shared with the CQC.
November 2021	CQC agreed an inspection plan for the Trust. Four core services were selected for inspection between 17 and 28 January 2022 which were the forensic inpatients/secure wards, (including the Edenfield Centre), acute admission wards for adults of working age and psychiatric intensive care units (PICU), child & adolescent mental health wards (CAMHS) and crisis and health-based places of safety services. A Trust well-led inspection was planned for February 2022.
26 November 2021	CQC report published from September 2021. Safe not rated: issues identified with management of ligatures and the environment.
29 December 2021	The CQC inspection planned for January 2022 was suspended due to national COVID-19 concerns and changing guidance about the impact of inspections on NHS at that time.

17 – 24 January 2022	A focused inspection by CQC of the child and adolescent mental health wards took place. CQC initially limited this to the safe domain based on an assessment of intelligence and reduced COVID-19 risks due to team size and patient group. This inspection was extended to comprehensive (although no concerns were found and therefore no risks identified).
March 2022	NHS Staff survey for 2021 published: the Trust scores are lower than the national average for morale, people promise and staff engagement.
Late March – late June 2022	Covert filming takes place at the Edenfield Centre by a reporter.
1 April 2022	An external well-led developmental review of the Trust started.
5 April 2022	CQC complete a focused inspection of community-based mental health services of adults of working age in response to whistleblowing concerns about staffing levels. This is limited to the safe key question.
6 April 2022	A routine 'safe and wellbeing review' was completed for a patient at the Edenfield Centre. This was part of a national programme which checked the well-being of all people with a learning disability or autism diagnosis held in a mental health hospital. This identified that the patient was being nursed separately from their peers in what amounted to long-term segregation, which had not been recognised by the Trust. This led to an Independent Care Education Treatment Review (IC(E)TR) being arranged.
21 April 2022	The CQC published the CAMHS inspection report. The service was rated as Outstanding in the caring domain and Good across all other key questions.
27 April 2022	CQC issued a s29A Warning Notice to the Trust following the focused inspection in April 2022 of community mental health teams in Manchester. There were significant concerns including in relation to managing risk and staffing.
23 June 2022	An 'Independent review of the use of long-term segregation' was carried out for a patient in response to the findings of the safe and wellbeing review in April.
29 June 2022	An Independent Care Education Treatment Review (IC(E)TR) was undertaken with a patient at the Edenfield Centre. The patient made several allegations relating broadly to 'bullying and mimicking/taunting' by staff. The list of allegations was long and detailed, including individual named members of staff taunting the patient; for example, saying that they were in seclusion because they are a baby, making a gun like gesture to their head through the seclusion room window and many more. They also highlighted some of the general restrictions and disruption on the ward, such as a lack of continuity in psychology staff, the ward environment being noisy, and a general lack of care.
29 June 2022	CQC published the report following the community mental health services inspection in April 2022. The CQC rating of Safe went down from Requires improvement to Inadequate.
13 June – 7 July 2022	CQC completed an inspection at the Trust. There were three core services inspected, acute admission wards for adults of working age and psychiatric intensive care units, forensic inpatients/secure wards and mental health crisis services and health-based places of safety, an overall well-led inspection was completed.
1 – 6 July 2022	Following the IC(E)TR findings, a quality review of the service where the patient was cared for was undertaken by Case Managers.

6 July 2022	CQC issues a s29A Warning Notice to the trust relating to the inspection of acute admission wards. This highlighted urgent safety concerns including management of fire risks and management of ligature risks.
18 July 2022	The Commissioning Committee meets for the first time since the IC (E) TR. There is no specific item on the agenda regarding the allegations made by the patient, but within a presentation on 'Management of Failure/Quality Concern Scenarios', one bullet point notes *'Concerns raised by an Independent IC(E)TR chair regarding the care of an individual patient placed with the lead provider which led to wider quality issues being identified.'*
20 July 2022	The report from the Case Manager review of service is received and an action plan is requested from the Trust.
25 July 2022	The Chair of the Commissioning Committee reports to the private part of the Trust Board that a safeguarding referral had been made following an IC(E)TR in the service.
3 August 2022	A formal response to the concerns raised by the Case Manager Review was sent to the Quality and Commissioning Hub from the service. Many of the issues raised are noted as already completed (such as environmental issues, advocacy, PMVA training).
14 August 2022	The Quality Improvement Committee (QIC) met and a paper broadly outlining the concerns raised by the Case Manager review of the service is presented.
30 August 2022	CQC issued a s29A Warning Notice following an inspection of HMP Wymott for concerns relating to medicines management.
8 September 2022	The BBC alerts the Trust regarding the upcoming broadcast. The Trust then informed stakeholders including NHS England and the CQC.
23 September 2022	CQC suspended the ratings for forensic services.
23 September 2022	CQC issued a s29A Warning Notice to the Trust relating to the inspections which took place in June and July 2022. The Warning Notice did include concerns at the Edenfield Centre. The Trust did not have sufficient numbers of suitably qualified, competent and skilled staff to ensure that patients received the care and treatment they needed and to keep them safe within the acute, psychiatric intensive care and forensic wards. The Trust did not have effective governance systems and processes in place to ensure that the acute, psychiatric intensive care and forensic wards operated safely and that risks to patients were assessed, monitored and mitigated. The Trust had not ensured that patients' privacy, safety and dignity within the acute wards were respected and maintained. Patients were provided with beds on mixed sex wards and in dormitory accommodation. There had been 26 sexual safety incidents on the mixed-sex wards.
23 September 2022	The CQC draft report was issued to the Trust which had a rating of Requires Improvement for well led.
28 September 2022	The BBC Panorama programme was broadcast depicting examples of bullying and abusive behaviour by staff which were similar to the concerns raised during the IC(E)TR.
29 September 2022	The Equality and Human Rights Commission write to the Trust Chief Executive setting out their concerns regarding the abuse that was shown in the BBC Panorama programme.
4 – 6 October 2022	The CQC inspect community-based mental health services for adults of working age. The safe and responsive domains are inspected.

22 October 2022	The CQC remove the ratings of well led and the overall rating from the CQC public website with the following message – "*We have suspended the ratings for this provider while we investigate concerns.*"
01 November 2022	The coroner issued a Prevention of Future Death notice relating to the death of a young person on the Gardener Unit, the forensic CAMHS service. This relates to issues with observations not being undertaken and signed as completed, blood results not being available and a lack of suitably experienced nursing staff on the ward.
4 November 2022	CQC issue a further s29A Warning Notice for community-based mental health services for adults of working age relating to oversight and governance and case load management.
8 November 2022	The Trust were placed into Segment 4 of the NHS Oversight Framework. This meant it entered the National Recovery Support Programme and would receive mandated intensive support.
16 – 17 November 2022	The CQC carried out a focused inspection of wards for older people with mental health problems at Woodlands Hospital. This was in response to concerns raised by a whistle-blower and following an MHA monitoring visit. A Letter of Intent was issued to the Trust following the inspection.
24 November 2022	The CQC report is published following the June/July 2022 inspection. The overall trust ratings are Inadequate for Safe, Requires improvement for Effective and Responsive and Good for Caring. The well led and overall trust rating would remain suspended pending a further inspection of the trust to be completed in early 2023. Both the Forensic core service and Acute wards and/PICUs core service were rated inadequate overall. Both services were rated as inadequate for the safe and well led domains and the remaining three key questions were rated as requires improvement. The Crisis & Health Based Place of Safety core service was rated Good overall and in all key questions.
20 December 2022	The CQC issued a s29A Warning Notice relating to the inspection at Woodlands Hospital. This centred on concerns relating to the management of ligature risks, environmental risks, medicines management, risk management/patient records and handover between staff, access to records and oversight of quality.
1 January 2023	An interim Chair joins the Trust.
31 January – 6 March 2023	CQC undertook an inspection of acute admission and PICU wards, forensic/secure wards and community mental health teams for adults. An overall well-led inspection of the Trust was also completed.
7 February 2023	The coroner issued a Prevention of Future Death report relating to the death of a patient on Griffin Ward, a ward for young adults at Junction 17. Issues relating to clinical risk assessment are highlighted.
17 February 2023	The CQC inspection report for wards for older people with mental health problems at Woodlands Hospital following inspection in November 2022 was published with the safe domain rated Inadequate.
21 February 2023	A contract performance notice was issued to GMMH's provider function (secure services) by NHS England specialised commissioning.
March 2023	The NHS Staff survey results were published. The Trust results for 2022 are among the lowest for all mental health trusts in England across many measures.

10 March 2023	The CQC inspection report is published following the inspection of community-based mental health services for adults of working age in October 2022. The safe key question remains rated as Inadequate, and the responsive key question is rated as Requires Improvement.
17 March 2023	The CQC issued a letter of intent to the Trust requiring urgent assurances relating to fire safety/smoking and ligature risks/audit.
18 – 20 April 2023	The CQC complete a focused inspection of Woodlands Hospital and identified improvements following the Warning Notice issued in December 2022.
21 April 2023	The CQC issued a Section 29A Warning Notice to the Trust. It noted that the Trust had failed to improve in response to a previous Warning Notice relating to management of ligature risks and fire safety.
21 June 2023	The CQC published inspection reports from the inspection in early 2023. The forensic/secure core service rating improved to Requires Improvement in all domains, the acute admission wards and PICU core service were rated Inadequate for safe and well led and remained rated as Inadequate overall. Community mental health teams had improved to being rated as Requires Improvement overall, with the safe and responsive domains rated Requires Improvement. The overall Trust Well-led rating remained Inadequate.
1 July 2023	The CEO steps down and an interim CEO starts at the Trust.
21 July 2023	The CQC published an inspection report for Woodlands Hospital following the inspection in April 2023. The safe domain is now rated as requires improvement; the other domains were not fully inspected. The report states *'At this inspection, the trust had developed action plans to address all of these areas. We were able to see all the areas of concern had improved and there were ongoing plans to ensure that progress was built on and improvement sustained. We also saw areas of good practice at Greenway ward including comprehensive care plans, risk assessments which were complete and updated daily and good medicines management.'*

Appendix 6 – Glossary of terms used

Term used	Definition
ADO	Associate Director of Operations
AFS	Adult Forensic Services
CAMHS	child and adolescent mental health services
CC	Commissioning Committee: a sub-board committee
CCG	clinical commissioning group
CCTV	closed circuit television
CEO	Chief Executive Officer: the role provides strategic leadership and management to the whole organisation
CHARM	Community for Holistic, Accessible, Rights Based Mental Health
CHPPD	Care Hours per Patient Day
COO	Chief Operating Officer: this is a member of the executive team and sits on the Board
CQC	Care Quality Commission
DASS	Director of Adult Social Services
EPR	electronic patient record
FAST	Forensic Advice and Support Service
FT	Foundation Trust
FTE	full-time equivalent
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GM	Greater Manchester
GMC	General Medical Council
GMMH	Greater Manchester Mental Health NHS Foundation Trust
GMW	Greater Manchester West NHS Foundation Trust
HR	Human Resources
ICB	integrated care board: they replaced care commissioning groups in April 2022
ICS	integrated care system: these are partnerships between organisations that meet health and care needs across an area
IC(E)TR	independent care (education) and treatment reviews
IMHA	independent mental health advocate: a specialist advocate
LP	lead provider
LPC	local provider collaborative: a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population
MAPPA	multi-agency public protection arrangements
MCA	Mental Capacity Act
MDT	multidisciplinary team

MFT	Manchester University NHS Foundation Trust
MH	mental health
MHA	Mental Health Act
MHOST	Mental Health Optimal Staffing Tool: a tool used to measure patient acuity and dependency to help plan staff numbers
MHSIP	National Mental Health Safety Improvement Programme
MMHSCT	Manchester Mental Health and Social Care Trust
MS Teams	Microsoft Teams
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
NED	non-executive director
NG10	Violence and aggression: short-term management in mental health, health and community settings (NG10)
NHS	National Health Service
NHS Long Term Plan	The NHS has written a Long Term Plan so it can be fit for the future; the plan is based on the experiences of patients and staff
NHS Professionals	NHS Professionals provides temporary clinical and non-clinical staff to the NHS
NHS England	NHS England
NICE	National Institute for Health and Care Excellence: an organisation which produces evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders
NMC	Nursing and Midwifery Council
NSS	National Staff Survey
OT	occupational therapist
PALS	Patient Advice and Liaison Service
PARIS	Patient Record Information System (PaRIS)
PBS	positive behaviour support: a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge
PCDC	People, Culture and Development Committee
PCREF	Patient Carers Race Equity Framework
PDG	People Delivery Group: a sub board committee
PICU	psychiatric intensive care unit
PMVA	Prevention and Management of Violence and Aggression: training in how to manage situations safely for patients and staff when patients become distressed
PP	People Promise
PRN	pro re nata: a term used for medicines which are prescribed for when they are needed rather than at set times
PSIRF	Patient Safety Incident Response Framework
Q&C Hub	Quality and Commissioning Hub

QI	Quality Improvement
QIC	Quality Improvement Committee: a sub board committee
QIODG	Quality Improvement Operational Delivery Group: a subcommittee of the QIC
RC	responsible clinician
RCA	root cause analysis
Regulation 28 PFD	Regulation 28 Prevention of Future Death report: The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths
RRN	Restraint Reduction Network
Safeguarding	Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality healthcare. Safeguarding children, young people and adults is a collective responsibility.
Section 17 leave	Section 17 of the Mental Health Act 1983 allows for certain patients who are detained under the Mental Health Act to be granted 'leave of absence' from the hospital in which they are detained for a specified or indefinite period subject to particular conditions specified in their leave care plan.
Secure services	Secure services provide care and treatment for individuals with mental and/or neurodevelopment disorders who are liable to be detained under the Mental Health Act (MHA) 1983, and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings.
SEIPS	System Engineering Initiative for Patient Safety
SLT	senior leadership team: the tier of leadership below the executive team
SOAD	second opinion appointed doctor: they safeguard people who do not agree to their treatment under the Mental Health Act or are too unwell to agree
SPA	supporting professional activities
Specialised Commissioning	Specialised Commissioning: the part of NHS England which commissions and oversees quality of services in secure services
ToR	terms of reference
VCSE	voluntary, community and social enterprise
WRES	Workforce Race Equality Standard
WTE	whole-time equivalent

Appendix 7 – References

(2021) September 2021 Board papers. Available at:
https://www.gmmh.nhs.uk/download.cfm?doc=docm93jijm4n9865.pdf&ver=12925 (Accessed: 08
September 2023).

(2022) National guidance on quality risk response and escalation in integrated ... Available at:
https://www.england.nhs.uk/wp-content/uploads/2022/06/B1497-nqb-guidance-on-quality-risk-response-
and-escalation-in-ics.pdf (Accessed: 08 September 2023).

(2023) July 2023 Board papers. Available at:
https://www.gmmh.nhs.uk/download.cfm?doc=docm93jijm4n12943.pdf&ver=16758 (Accessed: 08
September 2023).

(No date) NHS choices. Available at: https://www.england.nhs.uk/always-events/co-production/ (Accessed:
08 September 2023).

Acute inpatient mental health care for adults and older adults (2023) NHS choices. Available at:
https://www.england.nhs.uk/publication/acute-inpatient-mental-health-care-for-adults-and-older-adults/
(Accessed: 08 September 2023).

Allen, E. (2023) QNFMHS see think act, www.rcpsych.ac.uk. Available at:
https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-
forensic/forensic-see-think-act-qnfmhs/see-think-act---3rd-edition.pdf?sfvrsn=f8cf3c24_4 (Accessed: 08
September 2023).

Berwick, D. (2013) A promise to learn – a commitment to act – improving the safety of ... Available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/
Berwick_Report.pdf (Accessed: 08 September 2023).

Butterworth T (2022) What is clinical supervision and how can it be delivered in practice? Nursing Times
[online]; 118: 2, 20-22 (Accessed: 08 September 2023)

Caruso, C.C. (2014) Negative impacts of shiftwork and long work hours, Rehabilitation nursing: the official
journal of the Association of Rehabilitation Nurses. Available at:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4629843/#:~:text=Shift%20work%20and%20long%20work,c
ommute%20to%20and%20from%20work. (Accessed: 08 September 2023).

Charm Storybank, https://charmmentalhealth.org/

Coroners and Justice Act 2009 (2009) Legislation.gov.uk. Available at:
https://www.legislation.gov.uk/ukpga/2009/25/contents (Accessed: 08 September 2023).

COVID-19 mental health and wellbeing recovery action plan (2021)
https://assets.publishing.service.gov.uk/government/. Available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973936/
covid-19-mental-health-and-wellbeing-recovery-action-plan.pdf (Accessed: 08 September 2023).

CQC (2020) Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people,
and people with a learning disability and/or mental health condition. Available at:
https://www.cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf (Accessed 04 September 2023).

CQC (2022) Monitoring the Mental Health Act in 2021 to 2022. Available at:
https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022 (Accessed 27 September
2023).

Department of Health (2008) High Quality Care for All: NHS Next Stage Review Final Report Available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/
7432.pdf

Department of Health and Social Care (2014) Helping health and care services manage difficult patient
behaviour, GOV.UK. Available at: https://www.gov.uk/government/publications/positive-and-proactive-care-
reducing-restrictive-interventions (Accessed: 11 September 2023).

Department of Health and Social Care (2023) Rapid review into data on mental health inpatient settings: final report and recommendations, GOV.UK. Available at: ttps://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations (Accessed: 11 September 2023)

Department of Health and Social Care (2022) Maternity and neonatal services in East Kent: 'reading the signals' report, GOV.UK. Available at: https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report (Accessed: 20 September 2023).

Department of Health and Social Care (2011) Maintaining and improving quality during the transition: Safety, effectiveness, experience, GOV.UK. Available at: https://www.gov.uk/government/publications/maintaining-and-improving-quality-during-the-transition-safety-effectiveness-experience (Accessed: 21 September 2023).

Draft code of governance for NHS provider trusts - NHS England (2022) https://www.england.nhs.uk/. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/05/B0439-draft-code-of-governance-for-nhs-provider-trusts.pdf (Accessed: 08 September 2023).

Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, GOV.UK. Available at: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry (Accessed: 08 September 2023).

Francis, R. (2015) Sir Robert Francis' freedom to speak up review, GOV.UK. Available at: https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review (Accessed: 08 September 2023).

Freedom to speak up - NHS England (2022) http://freedomtospeakup.org.uk/. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/04/B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf (Accessed: 08 September 2023).

Greater Manchester Mental Health NHS Foundation Trust (2023) https://cms.nhsstaffsurveys.com/. Available at: https://cms.nhsstaffsurveys.com/app/reports/2022/RXV-breakdown-2022.pdf (Accessed: 08 September 2023).

Health and Care Act 2022 (2022) Legislation.gov.uk. Available at: https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted (Accessed: 08 September 2023).

Health and Social Care Act 2008 (2008) Legislation.gov.uk. Available at: https://www.legislation.gov.uk/ukpga/2008/14/contents (Accessed: 08 September 2023).

Kirkup, B. (2015) Morecambe Bay Investigation: Report, GOV.UK. Available at: https://www.gov.uk/government/publications/morecambe-bay-investigation-report (Accessed: 08 September 2023).

Markham S. (2020) Collaborative risk assessment in secure and forensic mental health settings in the UK. General Psychiatry 2020;33:e100291. doi:10.1136/ gpsych-2020-100291

Mental Health Act 1983 (1983) Legislation.gov.uk. Available at: https://www.legislation.gov.uk/ukpga/1983/20/contents (Accessed: 08 September 2023).

Mental Health Act 1983: Code of Practice (2015) https://assets.publishing.service.gov.uk/. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF (Accessed: 08 September 2023).

Mental Health Safety Improvement Programme (2023) Health Innovation Network. Available at: https://healthinnovationnetwork.com/projects/mental-health-safety-improvement-programme/?cn-reloaded=1 (Accessed: 08 September 2023).

Mental Health Units (use of force) act 2018 (2018a) Legislation.gov.uk. Available at: https://www.legislation.gov.uk/ukpga/2018/27/enacted (Accessed: 08 September 2023).

Mental Health Units (use of force) act 2018 (2018b) Legislation.gov.uk. Available at: https://www.legislation.gov.uk/ukpga/2018/27/enacted (Accessed: 08 September 2023).

Monitoring the Mental Health Act in 2021 to 2022 (2022) Monitoring the Mental Health Act in 2021 to 2022 - Care Quality Commission. Available at: https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022 (Accessed: 08 September 2023).

National Quality Board (2022) Quality Risk Response and Escalation in Integrated Care Systems. Available at https://www.england.nhs.uk/wp-content/uploads/2022/06/B1497-nqb-guidance-on-quality-risk-response-and-escalation-in-ics.pdf (Accessed 08 September 2023).

National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2022 (2022) NSPA. Available at: https://nspa.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-in-mental-health-annual-report-2022-uk-patient-and-general-population-data-2009-2019-and-real-time-surveillance-data/ (Accessed: 08 September 2023).

National Institute for Health and Care Excellence (2015) Violence and aggression: Short-term management in mental health, health and community settings, https://www.nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-pdf-1837264712389 (Accessed: 08 September 2023).

NHS England (2019) The Long-Term Plan. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf (Accessed: 08 September 2023).

NHS England (2020) WE ARE THE NHS: People Plan 2020/21 - action for us all. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf. (Accessed:08 September 2023)

NHS England (2022) NHS Oversight Framework. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf (Accessed: 08 September 2023)

NHS England (2023)a Acute inpatient mental health care for adults and older adults – Guidance to support the commissioning and delivery of timely access to high-quality therapeutic inpatient care, close to home and in the least restrictive setting possible. Available at: https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/ (Accessed 20 September 2023)

NHS England (2023)b Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme (Accessed: 25 October 2023).

NHS England (2022) Patient safety incident response framework -, https://www.england.nhs.uk/. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf (Accessed: 08 September 2023).

NHS England and Improvement (2019) The NHS Patient Safety Strategy Safer culture, safer systems, safer patients NHS choices. Available at: https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/ (Accessed: 08 September 2023).

NHS England and Improvement (2022) Plan, Do, Study, Act (PDSA) cycles and the model for improvement. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-pdsa-cycles-model-for-improvement.pdf (Accessed:08 September 2023)

NHS Providers (2015) https://nhsproviders.org/. Available at: https://nhsproviders.org/media/1738/foundations-of-good-governance-web-file.pdf (Accessed: 08 September 2023).

NHS Vacancy Statistics England, April 2015 - March 2023, Experimental Statistics (2023) NHS choices. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2023-experimental-statistics (Accessed: 08 September 2023).

NICE Guideline [NG10] (2015) Violence and aggression: short-term management in mental health, health and community settings. Accessible at: Violence and aggression: short-term management in mental health, health and community settings. Accessed: 05 September 2023)

Ockenden, D. (2022) Ockenden Review: Summary of findings, conclusions and essential actions, GOV.UK. Available at: https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions (Accessed: 08 September 2023).

Pollitt, A. and Pow, R. (2022) Supporting the Mental Health of NHS staff as part of post-pandemic recovery, https://nhscheck.org/. Available at: https://www.kcl.ac.uk/policy-institute/assets/supporting-the-mental-health-of-nhs-staff-as-part-of-post-pandemic-recovery-summary.pdf (Accessed: 08 September 2023).

Rapid Review into data on mental health inpatient settings: Final report and recommendations (2023) GOV.UK. Available at: https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations (Accessed: 08 September 2023).

System working and collaboration: The role of foundation trust councils of governors (2022) https://www.england.nhs.uk/. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/05/B0440-draft-addendum-to-your-statutory-duties.pdf (Accessed: 08 September 2023).

Treasury, HM. (2014) Devolution to the Greater Manchester Combined Authority and transition to a directly elected mayor, GOV.UK. Available at: https://www.gov.uk/government/publications/devolution-to-the-greater-manchester-combined-authority-and-transition-to-a-directly-elected-mayor (Accessed: 08 September 2023).

Trust - RXV Greater Manchester Mental Health NHS Foundation Trust (24 ... (2022) https://api.cqc.org.uk/. Available at: https://api.cqc.org.uk/public/v1/reports/7e549313-defc-4e4a-99b1-7e409d5b8870?20221129062700 (Accessed: 08 September 2023).

UK corporate governance code (2018) UK Corporate Governance Code | Financial Reporting Council. Available at: https://www.frc.org.uk/directors/corporate-governance/uk-corporate-governance-code (Accessed: 08 September 2023).

WE ARE THE NHS: People Plan 2020/21 - action for us all (2020) NHS choices. Available at: https://www.england.nhs.uk/ournhspeople/ (Accessed: 08 September 2023).

West M, Eckert R, Collins B, Chowla R (2017) Caring to change How compassionate leadership can stimulate innovation in health care The Kings Fund (2017). Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf (Accessed:08 September 2023)