Independent Assurance Review

Greater Manchester Mental Health NHS Foundation Trust

23 February 2026

Final report

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Final Report – 23 February 2026

This Final Report (has been written in line with the terms of reference as set out at 1.5 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Events which may occur outside of the timescale of this review will render our report out of date.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 version of this report should be regarded as definitive.

Introduction by Professor Oliver Shanley, OBE

Background

1.1 In January 2024 the independent review of Greater Manchester Mental Health NHS Foundation Trust was published. This work (referred to as 'the original review' throughout this report) was commissioned following concerns about the quality of care within the Trust in 2022, including appalling levels of abuse documented through a BBC Panorama documentary about the Edenfield centre. The Edenfield Centre is now known as 'Riverside' and is referred to as such in this report.

1.2 The terms of reference (ToR) for that work, which was commissioned by NHS England, required that an assurance review agreed in line with those ToR be undertaken within 12 months. The purpose of this assurance review is to determine the levels of progress made by the organisations to the recommendations made within our original report.

1.3 In early 2024, we made several recommendations, based upon what we saw and heard from multiple sources, most importantly for people who use mental health services or care for and support people who use services. The report highlighted that a significant improvement programme was needed, to cover many areas. These included, for example, the Trust's approach to supporting people using services and their carers, clinical models, workforce development, governance, estates and other matters, notably the culture of the organisation. We also made some recommendations about how the Trust is overseen by regulators and others, and the learning needed.

1.4 We were clear in making these recommendations, that transforming the culture of GMMH was central to the changes which needed to be made, and that the scale of change required was not to be underestimated. As we said at the time:

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.

Review scope

1.5 The same review team was asked by NHS England, North West region, to conduct this review of progress made by all organisations. Specifically, NHS England asked us to:

'focus on the actions that have been progressed and implemented in response to the recommendations made in the Independent Review. The NHS England-commissioned assurance review is primarily a desk top based review examining any evidence of improvement in relation to the recommendations made in the report published in 2024. This will include some focussed conversations and a site test visit to evaluate the impact of the trust and system partners response to the initial report.'[1]

1.6 As such, our work relied mainly on documentary evidence, which we were able to test and seek to corroborate through interviews, and in a site visit to the Riverside Centre in August 2025.

1.7 Desktop based methods can limit the extent to which reviewers can used systems-based approaches (such as the SEIPS[2] framework used in the original review), although we have sought

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[1] NHS England — North West » Independent review - Greater Manchester Mental Health NHS Foundation Trust

[2] SEIPS quick reference guide, NHS England, 2022

to be thorough and to be diligent in trying to understand the context within which each organisation has been working to implement our recommendations.

1.8 Of note, several people contacted the Independent Review Chair to ask the team to explore some additional areas. These went beyond the review scope, and we raised this with NHS England who confirmed that there would be no changes to the remit of the assurance review. Where views expressed to us were relevant to our brief, these have been included in this report.

Review methods

1.9 This work took place between July and October 2025, during which time the review team:

- **Undertook a detailed documentation review.** This was based primarily on evidence sent to us by each organisation, and the sources of assurance they had collected to show progress. We were also sent and considered information proactively by several people who work at or are stakeholders of GMMH.
- **'Confirmatory interviews'.** We then held a series of conversations with individuals including people with lived experience, carers and people working in the third sector, as well as those working within several of the organisations. The purpose of these meetings was to test what we had read in our documentation review, and to understand the context around the actions taken.
- **Visit to the Riverside Centre.** In late Summer 2025, we visited the Riverside Centre. Over two days, we met with patients, carers, staff and leaders to see the changes made in real time. We conducted several focus groups during this visit.
- **Analysis.** As a team, we shared our findings to understand key links across the different areas, and their impact on each other. We were asked to use an established numerical scoring system to rate progress, which has been used on similar reviews in other mental health trusts following serious concerns about the quality of care. The outputs of this analysis are shown at the end of this section.

Key context

1.10 All parties involved in responding to our original review have been doing so at a time of significant change in the NHS. For GMMH specifically, since the publication of the independent review, the majority of the Board of Directors and specifically the Executive Directors at GMMH have changed. A substantive CEO was appointed in June 2024, who has recruited a permanent executive team, which is now in place. Prior to this, several interim executive directors had been in post. This is important as the ability of the organisation to respond to the recommendations has inevitably been impacted by the need to recruit and embed a substantive executive team, which can then set a coherent direction for the organisation.

1.11 In addition, the abolition of NHS England was announced in March 2025. This has had subsequent and significant impacts on Integrated Care Board (ICBs). In turn, these bodies have concurrently been asked to cut their workforce by 50%.

Key messages arising from this work

1.12 Across all the recommendations, we found that progress has been made. While this has certainly been delayed by the changes in GMMH's leadership, we found overall that positive foundations for improvement are now being substantially put in place. The sustainability and impact of these is too early to assess at this stage.

1.13 In our original report we spoke about the principle of understanding 'work as imagined versus work as done.' It is key that the Trust, in implementing various new strategies, policies and plans, that feedback is regularly taken from staff and service users, so that changes are grounded in the reality of how care is delivered and received; listening to people will be central to sustaining improvements.

1.14 There are still areas where significant work is required, and we heard some reservations from people with experience of using services, their loved ones, carers and staff, about the organisation's commitment to change. For some, there remains a lack of trust, and this will take time, energy and commitment to restore. Trust leaders we spoke to acknowledged and understood this perspective. They acknowledged that the changes required can only occur though changing culture, building trust, and co-producing a better experience for service users and their carers.

1.15 At the time of writing, GMMH remains in the highest level of oversight by NHS England. This means that it is subject to additional assurance processes, with more intensive oversight and scrutiny, and mandated support and improvement plans. This rating can also mean restrictions on spending and autonomy that trusts in a better position do not face. It is a challenging position for an NHS organisation. During the finalisation process of this report, GMMH exited the Recovery Support Programme and was placed in Segment 4 of the Oversight Framework.

1.16 As a result of this rating, the Trust has been working to a set of 'exit criteria' which it must meet to improve its rating and include the basics of financial viability, care quality, performance and staffing. Demonstrating compliance with these standards, coupled with the time taken to recruit a substantive executive team and Board, appears to have led to a loss of pace around the cultural needs of the organisation. As and when the Trust exits the highest level of oversight, some positive groundwork has been laid to now focus in earnest on these areas.

1.17 The degree of progress being made seems to rely on the nature of the recommendation; we saw the greatest impact made in more transactional areas (such as estates) and the least impact in areas which require substantial culture change, especially patient engagement. This is not altogether unexpected and, as we highlighted in our original report, meaningful culture change takes time, particularly considering how things were in the Trust in 2023 and prior.

1.18 Some people we spoke with described an apprehension that (in the speed to improve the organisation), some new senior colleagues may not appreciate the depth of concerns that existed previously within GMMH, having not been directly involved in these events, and therefore may risk not understanding how deeply poor care and culture had become entrenched in some parts.

Outside of GMMH:

1.19 We were concerned about the ICB's lack of progress in commissioning an independent review of community mental health teams. This was a source of particular concern for various people we heard from. This is now underway, and we have not seen the outputs of the work.

1.20 There have been significant staffing challenges in the Lead Provider Collaborative[3], and these may deteriorate further due to the changes in NHS England. A decision about successor arrangements to provider collaboratives remains outstanding, and these factors pose a risk to the effective oversight of forensic inpatient services.

1.21 There were differences in how the organisations involved in overseeing GMMH sent evidence to us for this assurance review; this is in part due to the uncertainty about oversight structures as a result

[3] A lead provider collaborative is when a single trust takes responsibility to deliver a set of services on behalf of the provider collaborative. 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.

of NHS England being abolished, however it does not appear that a systematic approach was taken by all organisations involved to reflecting on and implementing our recommendations prior to this assurance review being announced.

Assurance summary

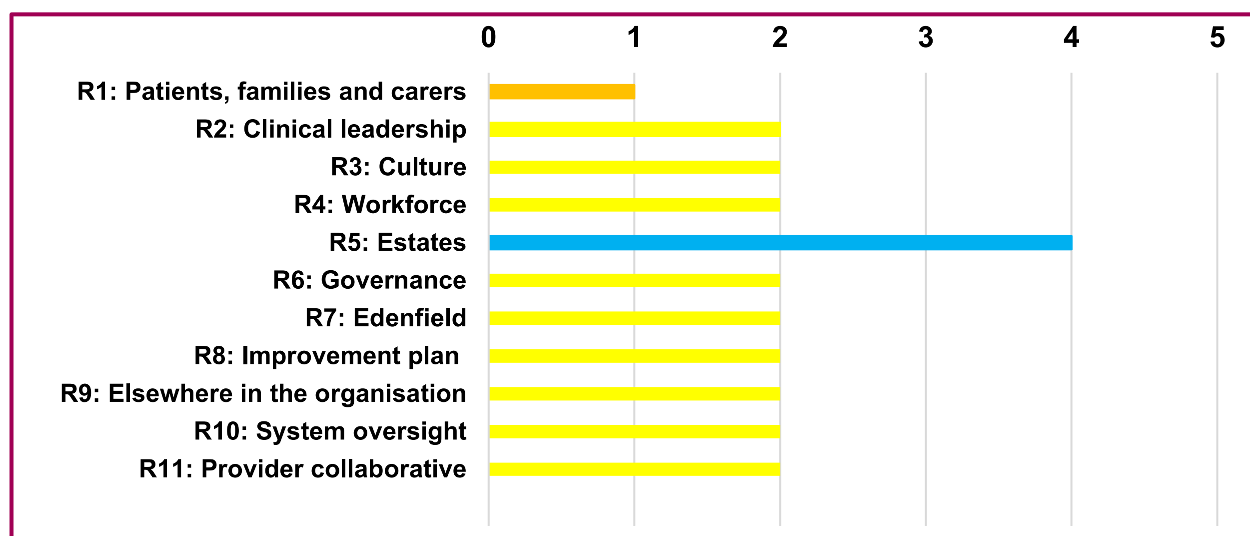
1.22 We have used a numerical scoring system to show 'progress ratings'. These are intended to help each organisation focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained improvements. To support with this, we have highlighted residual recommendations where there remains work to do to deliver these fully.

Assurance framework applied: Rating definitions

Rating	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action completed, tested, but not yet embedded
5	Can demonstrate a sustained improvement

Assurance ratings

1.23 As outlined above, progress has been made across all areas, but the extent of this varies. It is noteworthy that most areas have been rated as '2'. This rating indicates that actions are significantly progressed (but not yet completed, embedded and tested). This, to us, is indicative of the context outlined within this section. Ratings include:



Recommendation 1: Patients, families and carers

1.24 As follows are our key findings against each of the recommendations made:

<table>
<tr><td colspan="2">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.

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.</td></tr>
<tr><td>Assurance rating for this recommendation</td><td>1</td></tr>
</table>

Key findings

1.26 We have scored this recommendation as 1. The Trust has made progress in establishing a framework for service users and carers to be heard, however this is not yet delivering the impact needed to make lived experience voices central to the design, delivery and oversight of its services. We saw and heard evidence of consultation rather than co-production.

Review the Service User Engagement Strategy with all relevant stakeholders. This evaluation must assess the degree of cultural sensitivity and responsiveness enabled by the strategy.

1.27 It is clear from several reports, including those to the System Improvement Board, that GMMH has put a lot of effort into this action. The Trust completed a review of the Together Strategy, six months before the existing Strategy's end. This was approved at Board in September 2025. The resulting 2025 - 2030 Strategy informed by service users, carers, and staff asserts it will build on the progress made over the past three years and focus on:

- Meeting needs together.
- Learning together.
- Developing services together.
- Working together.
- Investment in the Engagement Team to support delivery of Patient and Carer Race Equality Framework (PCREF).

1.28 The Strategy includes specific reference to working "*in partnership with the universities and VCSE sector with a particular commitment in 2021 to learning from under-represented groups especially people from Black, Asian and Minority Ethnic communities who are often over-represented in*

secure services and underrepresented in community services". The new Strategy further commits to learning from its "*experiences of being a national Patient and Carer Race Equality Framework site*" to " *improve access to mental health support for people from Black, Asian and Minority Ethnic communities*", in addition to working with the "*VCSE sector to listen more to underrepresented groups and people with protected characteristics, especially people from Black, Asian and Minority Ethnic groups, people with learning disabilities and autism, and people who identify as LGBTQ+..*"

1.29 Resource has been considered as part of this, with an acknowledgement that this has historically been insufficient to deliver previous goals. We explore this further at Recommendation 6. As a result, the updated version of the strategy is still in its infancy.

1.30 Some positive progress has been made in implementing the Together Strategy and there are now 64 people working in lived experience roles across the Trust (a Lived Experience Career Pathway has also been implemented). However, the patient, service user and carer feedback we received implied this is not happening in any significant or consistent manner. This is further evidence that the Trust strategy has not yet permeated the organisation and led to the desired outcomes it aspires to achieve.

1.31 Compared with our previous review, there is now more proactive senior leadership on this agenda. The Chief Nurse was frequently cited as someone who understands the importance of working in partnership with people with lived experience and their carers. We also heard positive comments about those who are leading on this agenda at both corporate and local delivery level.

1.32 We heard that there remains work to do to ensure that all those in leadership roles fully understand and endorse the importance of service user engagement and co-production. Some service users and staff reported a perceived lack of sincerity in the Trust's approach, and a sense that the Trust leadership is focused on doing its best to "maintain appearances" rather than being open about any difficulties it is experiencing, or responding to patient, service user and carer concerns. We were told on several occasions about a specific example that had damaged trust about the commitment of leadership to user involvement involving a senior Trust leader.

1.33 People with lived experience told us that, to enable the success of the strategy, the Trust must redouble its efforts to listen to people with lived experience and focus on seldom heard voices which may not always be fully represented by some organisations seeking to enable change. We also heard that the need to engage communities was particularly important to address the diverse nature of the people and communities the Trust serves.

1.34 There were mixed views among services users, carers and advocates about the changes in this area since the publication of the original report. Some people describe positive changes albeit with much more to do. Other people feel that a culture where service users and carers are valued remains a distant goal. A further group of people told us that they felt this agenda diminished during the tenure of the interim executive team.

1.35 There is evidence from some voluntary, community and social enterprise (VCSE) organisations that work to try and strengthen the voice of service users has been welcomed and is having some early positive effect. Other views from external groups in relation to this agenda included:

- A local service user-led organisation has expressed a perceived failure of the Trust to revise and restructure services, address racism and provide adequate support for whistleblowers. They expressed their perceived need for the Trust to "go back to basics" and better understand what is and is not working.

- A VCSE partner stated they have welcomed the Trust's commitment to actions following their feedback as part of Patient and Carer Race Equality Framework. This group is working with the Trust and the Patient Council to co-produce a new Standing Operating Procedure and training resources around improving medicines reconciliation and optimisation.

Systems to represent and respond to patients' expertise at every level

1.36 There is now increased resourcing in the patient involvement team, and Patient Advice and Liaison Service (PALS) roles have been re-established within Care Groups to strengthen local responses. Further, the PALS and Complaints Policy was revised with input from service users, carers, and staff to ensure thorough investigations and senior oversight of complaints. However, senior leaders told us that they had to revisit a significant number of historical complaints, concerns and investigations as these had not been dealt with appropriately and that considerably more work was required to build and sustain trust.

1.37 We note that these approaches, while positive, are focussed on reacting to matters which have already occurred. The Trust has yet to actualise desired levels of co-production with patients and carers, relying mainly on consultation.

1.38 The service users involved are keen to enable the Trust to improve but some expressed the view that they are hindered in doing so by a perceived lack of commitment to engagement and co-production. We think this is further indicative of the delayed implementation of the strategy and the need to build trust amongst people who use services.

1.39 In terms of using patients' expertise, a Patient Council and a Carer Council are now in place to strengthen the voice of these groups, and to build this into the Trust governance structure. Both have co-produced their terms of reference. These groups have been engaged in the development of key initiatives aimed at driving culture change in the Trust, including the Behaviour Framework, and new Involvement Standards.

1.40 However, the Carer's Council has faced difficulties in recruiting to and sustaining membership. There were also concerns that the membership of these groups was small, and did not reflect the scale or complexity of the Trust yet.

1.41 There is currently some discomfort about recent changes to representation and reporting arrangements from these forums, and the Trust will need to clarify the rationale for these changes with the councils' members. This included needing further assurance that the voice of people with lived experience is heard at the Trust Board.

Systems to represent and respond to family and carers' voices at every level of the organisation

1.42 We heard directly from carers how, in some services, they were positive about local efforts to listen to their concerns and offer support. We also heard from the same group that they still felt that there were not always the levels of empathy, kindness and communication from staff that would really enable them to feel like a valued partner in care.

1.43 The new Carers' Standard Operating Procedure (SOP) and staff training programme has been co-produced with carers involved in complaints and serious incidents and rolled out across the Trust.

1.44 In relation to Triangle of Care, the Trust has retained the two-gold star status for its commitment to carers by having Carer Champions in local services, compliance in carer training, identifying carers, having policies and processes in place, carer information, and having/being aware of local carer support services.

1.45 Further examples of positive work in relation to working together with service users, families and carers has included:

- A co-produced approach to implementing Martha's Rule[4].
- The Trust is working with external researchers, partnering with service users, carers, families, and community groups to explore the 'Soteria' approach; an alternative approach to inpatient psychiatric admission for people experiencing serious mental illness.
- In Spring 2024, an externally facilitated engagement programme took place with the Trust's servicer users, carers and families to inform the new Trust strategy. The views of 45 service users, their carers, advocates and families were captured through this work.

Residual recommendations

1.46 While some positive progress has been made with new systems, processes, and roles in place, expected outcomes are still emerging but still fall short of patient, service user and carer expectations. There is a need for the Trust to revisit the recommendations to understand this discrepancy better and work more closely, transparently and responsively with patients, service users and carers to make further progress.

1.47 We also identified the following improvement opportunities:

- More transparency and closer working with patients, service users and carers would help move from consultative to co-produced approaches, and would further help engender the trust required to enable change.
- More testing and evaluation will be required to see if the new and enhanced infrastructure and innovations such as new research have good effects which are sustained.

[4] Martha's Rule is a patient safety initiative designed to ensure that concerns from patients, families, and carers are heard and acted upon when their loved one's condition worsens. Inspired by the death of Martha Mills and similar cases, it gives families the right to request a rapid clinical review if they feel their worries are being overlooked.

Recommendation 2: Clinical voice

<table>
<tr><td colspan="2">A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.

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.</td></tr>
<tr><td>Assurance rating for this recommendation</td><td>2</td></tr>
</table>

Key findings

2.1 We have scored this recommendation as 2: the Trust has done substantial work to establish a framework which supports the clinical voice, however, most of this work has only been formalised within the last six months. Whilst a good foundation has been laid, there is much work still to be done to fully implement and embed the actions described, and to ensure that the benefits are experienced across the Trust and by patients and families who use services.

2.2 Overall, the strategic direction of the Trust has changed and it has been working to lay the foundations on which clinical leadership can thrive. Action has been taken to develop strategy and design an infrastructure that supports this aspiration. This includes strengthening the quality governance structure to make quality and safety accountabilities much more visible, strengthening the executive and corporate capacity in these areas, and introducing new roles to raise the profile of clinical disciplines at a senior level.

2.3 New strategy, workforce plans and training opportunities are being developed and implemented and there are numerous new job roles being introduced and appointed to across professions that reinforce the renewed focus on the quality and safety of services.

2.4 Additional forums are being developed through the services that hope to facilitate clinical expertise being present across and within services.

2.5 Despite these positive changes, and the extent of investment in this area, there remain concerns in some areas that the voice of clinical staff is still not being heard sufficiently in all change initiatives. This includes in the transformation of community services.

2.6 One aspect of the recommendation remains outstanding: an evaluation of the triumvirate leadership model.

2.7 This chapter sets out our findings in relation to each of the component parts of Recommendation 2. Its findings are closely related to those in Chapter 3, which explores the Trust's culture.

Systems for developing clinical leadership

2.8 The Trust People Strategy was launched in June 2025 and includes goals that support staff learning and talent management. In support of delivering this strategy, professional three-year plans (2025 - 2028) have been developed over the last six months in nursing, psychology and allied health by clinical executives for their service delivery.

2.9 Roles have been developed or redesigned to support a more robust approach to quality and raise the clinical voice within the organisation. Some examples of these include:

- Two new deputy Medical Director posts
- A Director (and separate Head of) Allied Health Professionals (AHPs)
- An Associate Director of Psychological Services
- A Nurse Consultant for Reducing Restrictive Practices
- Additional leadership in the Safeguarding function
- New Associate Directors of Nursing (and Heads of Nursing)
- Quality matrons, who are working across services to support resuscitation training
- A positive and safe trainer, who will focus on reducing restrictive practices.
- Two HOPE(s) practitioners
- Two Human Rights Officers

Clear role profiles have been developed for each, which emphasise the oversight of quality and safety.

2.10 We heard about the value that new nursing roles are providing, which included improved experience of supervision, role modelling and supporting the development of practice i.e. the clinical skills needed to support reducing restrictive practice. We heard that this leadership was present and visible in clinical environments within Riverside. We also heard that the quality matron roles have been bringing focus to supporting roles in services for example estates, ensuring a clear understanding of their importance in delivering high quality, safe services. It will be important to ensure that this sort of leadership is enabled across the organisation.

2.11 A new Chief Medical Director (MD) started in post in October 2025 and has taken over from an experienced interim. The organisation has planned a period of crossover between the two individuals in this role and will need to be sure that the new MD has the time and support to build on the work already undertaken in this area. In recognition of this, two new Deputy Medical Director roles have recently been appointed to, and the Associate Medical Director roles have been redefined to work across care pathways within GMMH. New roles have been created to support delivery of the responsible officer function. Some of those we spoke to did reflect on the lack of women in senior Trust medical leadership.

2.12 The new Trust governance structure is described at 6.5 onwards. Within this, several forums have been introduced to strengthen and recognise the importance of clinical leadership. These include Clinical Network Meetings, and a Clinical Senate, which is described as providing a safe forum for clinical staff to discuss matters important to them.

2.13 A new supporting Learning and Development Policy was developed and ratified in July 2025. The Trust has put in place a series of interventions to help clinical staff to improve their skills. These include:

- An externally delivered programme for the Care Group triumvirates was completed. A second programme to accompany the newly reorganised Care Group structure, is now in development.
- An externally delivered quality matron development programme started in March 2025.
- A new consultant development programme started in February 2024 and two cohorts have been completed. A further programme is in development.
- Five senior leaders are currently taking part in the NHS England North West Directors and Aspiring Directors development programme facilitated by the North West Leadership Academy.
- 'Role model. Coach. Care' leadership training has been delivered to more than 1,580 staff members.
- There is an internal coaching network with 48 coaches available to deploy. Around 80 members of staff have received 'everyday coaching conversations training'. A leadership development suite is also planned, tailored to managers' responsibilities.

2.14 The impact of these interventions has not yet been evaluated, and the Trust will want to be assured that the significant investments made in these roles and structures is delivering the intended benefit.

High-quality supervision, mentoring and coaching

2.15 Medical appraisal and revalidation systems have significantly improved since the time of our original review. There is a new medical appraisal policy which was ratified in March 2025. An electronic system for managing the appraisal process has replaced the manual process and provides automated reminders, collation of feedback reports and governance reports. These improvements have been externally validated by a Higher Responsible Officer[5] Visit in May 2025.

2.16 Medical appraisal rates are now excellent with every doctor present at work and connected to the Responsible Officer in the organisation having had an appraisal in the last appraisal year. Work is now focused on processes to ensure the quality of the appraisal itself, which we support.

2.17 The Trust has also developed a medical appraisal and revalidation peer review system with a neighbouring Trust which creates further assurance and opportunity to learn. Medical job planning policy and procedure has been developed and 95% of doctors now have a job plan on the Trust's system.

2.18 Work on improving clinical supervision for nurses started in February 2025 and the improvement programme is set to complete in December 2025. Between July 2024 and January 2025 supervision levels remained steady around 75%. Since then, rates have started to improve with 80.3% reported in July 2025 data[6] and 81% in September data. Appraisal data has shown no sustained improvement since July 2023, with appraisal rates at 78% (July 2025 data) A process has been agreed to develop equivalent clinical supervision for senior doctors. The Trust reported 71% for clinical supervision for all disciplines across the Trust in April 2022 and was reported as 72% in September 2025.[7]

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[5] Responsible officers oversee the revalidation process for doctors within their organisation. They are accountable to the higher level responsible officer/regional medical director at NHS England.
[6] September 2025 Board paper with July 2025 data
[7] People Metrics at the People and Culture Committee, September 2025

2.19 We did not see information or hear about any formal mentoring processes within the Trust, although note the coaching offer described above. We remain of the view that this is a key part of ensuring that new clinical leaders are set up for success.

2.20 Given the issues outlined in relation to racism within our original report, equity of opportunity should be central to improving the clinical leadership within the Trust. There is now more focus on this, and we saw defined objectives to reduce racism and structural inequalities within key documents, such as the Nursing Plan. However, in our field work it was evident that staff continue to experience racism, and the actions the Trust is taking are not yet producing the improvements needed. Staff we spoke with gave examples of being racially abused by patients. We heard that financial constraints may be impacting some areas of the improvement work needed. This issue is explored further in Recommendation 3.

Evaluate the effectiveness of the care group triumvirate model

2.21 A review of the Care Group structure is currently underway. As such the organisation is not yet able to review the effectiveness of the triumvirate model.

2.22 In line with the organisational change process, affected leaders have been asked to preference positions. Some managers we spoke to told us that this creates a risk of people self-selecting areas to work in, in which they have limited or no experience. The impact of this needs to be considered.

Residual recommendations

2.23 The Trust has invested significantly in new training and opportunities for staff; it will be important to ensure that maintain a focus on the outcome of this investment in understanding and adjusting if their offer is not delivering the intended improvements.

2.24 Outstanding elements of this recommendation must still be delivered, including an evaluation of the triumvirate leadership model.

Recommendation 3: Culture

<table>
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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.

The Trust must continue to 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 supports 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.

</td></tr>
<tr><td>Assurance rating for this recommendation</td><td>2</td></tr>
</table>

Key findings

3.1 As outlined in our original report, culture takes a long time and much perseverance to change. We have scored this recommendation as 2: the Trust has developed a strategy and a number of policies in response to the recommendation. These have not yet been fully implemented and it is too early to demonstrate the impact of actions taken. Given the recency of the new Executive Team and the wider Board, this is to some degree, to be expected.

3.2 Much of the work done by the substantive executive team was seen as an important direction of travel for the organisation, but many we heard from felt it was too soon to determine the impact or benefits of the various strategies and policies yet. Some described an apprehension that (in the speed to improve the organisation), some new senior colleagues may not appreciate the depth of concerns that existed within GMMH, and therefore may risk not understanding how deeply poor care and culture had become entrenched in some parts.

3.3 The recommended actions related to racism and discrimination have not had the desired impact, with poorer outcomes now being evidenced through the Workforce Race Equality standards contained within the National Staff Survey. Actions taken in this area need to be reviewed and prioritised.

3.4 This chapter sets out our findings in relation to each of the component parts of Recommendation 3.

Values and behaviours expected from all staff

3.5 In responding to concerns regarding organisational culture, the Trust has launched a new People Strategy in mid-2025, which sets out five priorities, these include: colleague wellbeing, inclusion (including becoming anti racist) and talent management. The strategy states that 800 colleagues had input into its content. The document outlines how it is underpinned by a values and behaviours framework to enable positive cultural change.

3.6 We note that the Trust is only in month four of delivering this at the time of our writing; The strategy, combined with several other new policies, are at the very early stages of responding to the cultural challenges across the organisation. Some staff we heard from were aware of these new strategies and policies, other were not.

3.7 As outlined throughout this report, the Trust Board and in particular the Executive team are relatively new in post. NHS Boards and executives have a key role in setting 'the tone at the top' to drive a healthy organisational culture. It was positive to see that the Board has received various development sessions on a range of subjects including anti-racism practices, quality improvement and Board assurance processes. The outputs from these sessions show a clear focus at Board level on key culture themes, including trust, psychological safety and openness. Papers from these sessions show a clear intent to move from an environment of "*secrecy and scrutiny towards transparency, assurance and collaborative* leadership".

3.8 A behaviours framework has also been implemented for all colleagues, following approval by the Board in May 2025. This was launched alongside the delivery of civility and respect workshops. The framework is planned to be embedded into Trust policies, procedures, development activities, supervision and appraisal. Staff survey results show ongoing concerns relating to kindness and civility. We heard from some staff and people who use services that these aspirations are yet to be fully implemented or experienced.

3.9 This suggests that the Trust's leaders, its partners and stakeholders need to remain vigilant to the Trust culture. Despite the positive intent in this area, trust will take time to rebuild, and role modelling these values and behaviours in all aspects of managing the organisation will be key in doing so.

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.

3.10 An important measure of organisational culture is the annual National Staff Survey. The Trust's most recent survey, which was undertaken in October and equality November 2024 and the results published in March 2025, showed a response rate of 45% versus a national median of 54%. The results overall show GMMH scored lower than the national average on all except one theme, although all areas show improved scores compared to 2023. These include scores relating to a compassionate culture and leadership, morale and staff recommending the Trust as a place to work. The Trust also attained the best score in the country for staff feeling able to report experiencing bullying and harassment with a score of 71% versus a national median of 64%. The Trust received a certificate of recognition from NHS England for these improved results.

3.11 The Board report attached to the most recent Staff Survey notes the improvements shown, but candidly identifies that "*results show unfavourable comparison to benchmark trusts in all categories*". It also identifies engagement as one of the biggest areas of concern for the Trust. The results show there is considerably more work to do on organisational culture. However, the presentation of the survey results seems to be more in keeping with a transparent culture and this is a positive indicator for change.

3.12 The People and Culture Committee and Trust Board now receive an improved level of information about the workforce, with appropriate metrics more routinely received. This includes a new People and Culture dashboard, reviewed by the committee. Current performance in these areas is set out at Recommendation 4.

3.13 In addition, the committee receives more qualitative reports on various relevant areas including, the cultural development programme, FTSU and the Staff Survey.

3.14 Pulse Surveys are now undertaken, to assess organisational culture on a more frequent basis than is possible through the National (annual) Staff Survey. The July 2025 Board Performance Report showed a decreasing score since the high of 6.6 in September 2024 to 6.4 in June 2025. It notes that engagement is a priority area for improvement and initiatives to improve have started, including the All Leaders Forum and a planned All Colleague Forum. The impact of these initiatives needs to be closely monitored.

Develop systems which supports a culture of inclusion and engagement that addresses concerns in relation to equality and racism

3.15 There is an Advancing Equity and Inclusion Strategy that is due to end in 2025, and we heard that the Trust intends to develop a new strategy that reflects their commitment to addressing lack of inclusion and difficulties with racism.

3.16 There is an updated policy and governance structure to start to address concerns regarding lack of inclusion and engagement specially in relation to race. This includes the establishment of an Anti-Racism Steering Group and a developing network of EDI champions. Training has been provided to staff including 'active bystander' sessions.

3.17 The Trust has taken further steps to try and address racism and won an international mental health award for a quality improvement project to reduce racism across the Trust.

3.18 The Trust Board is aware that there remains significant work to do in this space; in a recent self-assessment the Board identified that EDI was an area that requires significant improvement and self-rated this as 'red'. This was echoed by some colleagues we spoke to who outlined that there remain concerns about racism still being present across various areas of the Trust. We heard examples of racism from staff to staff, patient to staff and staff to patient.

3.19 The National Staff Survey results (2024) used within the Workforce Race Equality Standard show that the Trust scored worse than average in three or the four indicators, and the worst scores since recording started in 2020. These related to:

- staff experiencing bullying from patients
- staff experiencing bullying from staff
- discrimination experienced by their direct line manager

More encouragingly staff reported that that the organisation provides equal opportunities for career progression or promotion.

3.20 The Freedom to Speak Up Quarterly Report highlighted that there is a high awareness and engagement with FTSU which means that there is a route for staff to speak openly and raise concerns. The Trust has 103 FTSU champions as at 21 October 2025. The report noted that there had been an increase in concerns raised about discrimination although the numbers are small. These results had been shared with the Equality, Diversity and Inclusion Lead and an action to monitor. We heard concerns regarding Trust leadership not reflecting the diverse nature of the workforce, we also heard that in some clinical disciplines, specifically medicine, there was a perception of lack of representation from women in senior leadership roles.

3.21 We were told that there is a genuine commitment from staff and patient groups to support the organisation and these could be better harnessed by the Trust. Various examples were provided to

us, including the work of staff networks. The staff networks are a key source of support and challenge to the Trust. The Trust should ensure the networks are seen as an important ally in enabling change, and they should have sufficient time and resource to enact this.

3.22 We also heard concerns regarding the lack of racial diversity in the Trust's leadership, and in the medical leadership roles. As outlined at Recommendation 2, some also reflected on the lack of representation from women in senior medical leadership roles.

3.23 We heard that much of the work done by the executive team has been an important start in setting a new direction of travel for the organisation. Many felt it was too soon to determine the impact or benefits of the various strategies and policies. There was a view that these have yet to permeate fully throughout the organisation and, until then, it will be difficult to discern their overall impact on the culture of GMMH. Some people felt that there is a need for continued resourcing of organisational development to help the Trust make and sustain the changes that are required. They also described some 'entrenched cultural behaviour' that requires continued attention.

Review the current leadership programme and ensure that its content covers these key areas.

3.24 The extent of leadership development programmes now in place is described at 2.8.These are at various stages of implementation, and have not yet been evaluated. We also repeat here the newness of the Executive, and some Care Group leadership teams.

3.25 While there has been a clear focus on culture within Board and senior level programmes, there is an acknowledgement that work with 'middle managers' was essential, as this is where key strategies and policies are most frequently applied. This now needs to be a key area of focus, so that the positive intent at the top of organisation is fully realised.

Residual recommendations

3.26 The Trust and its partners must ensure they remain vigilant to their expressed changes in culture being realised, and routinely assess the impact of actions taken to ensure that these are having the desired effect. This must be informed by people who use services, with feedback routinely sought. See also Recommendation 1.

3.27 Actions taken in relation to racism and discrimination have not had the desired impact, with poorer outcomes now being evidenced. Actions taken in this area need to be reviewed and prioritised.

3.28 We also identified some further learning opportunities:

- Ensuring that people can speak up about any concerns without fear of reprisal or repercussions.
- Better utilising staff networks and patient voice groups to address long-standing concerns regarding discrimination and racism, and ensuring that these forums are sufficiently resourced to enable this.
- Continued resourcing of organisational development to help the Trust make and sustain the changes that are required.
- Considering how changes made through the Culture of Care transformation programme in inpatient services (which focuses on how trauma-informed, autism-informed and anti-racist approaches to care on a sample of wards) can be expanded across the wider Trust.
- A need for ongoing vigilance about the intended culture change becoming embedded and a reality for all staff, and consideration of service user views can be captured to inform this.

Recommendation 4: Workforce

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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.

Within 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 is supported.

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<tr><td>Assurance rating for this recommendation</td><td>2</td></tr>
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Key findings

4.1 We scored this recommendation as 2: The Trust has made significant progress towards this recommendation and whilst much has been achieved, there remains work to do to complete all aspects of our recommendation. Key areas where further focus is required include: the emerging cultural divide between newer and more experienced staff (and its impact on resourcing), embedding a just culture, and training and development. This was acknowledged by the executives we met and plans are being further developed to drive improvements. Whilst the interim leadership team worked to stabilise the workforce, we heard that the recent appointment of permanent executives had provided clarity of vision.

4.2 This chapter sets out our findings in relation to each of the component parts of Recommendation 4.

Develop a strategy for the recruitment and retention of staff and an associated delivery plan

4.3 Chapters 2 and 3 have described the intentions of the new People Strategy, which covers the next five years. Within this section we assess its early impacts.

4.4 Workforce metrics as of September 2025 were showing some challenges in this area, for example:

- vacancy rates stood at 11.26% (versus a target of 8.8%)
- turnover was 10.9% (versus a target of 10.5%). Within this headline figure, medical vacancies were 16.77% and AHPs were 11.35%. While turnover overall is almost on track, this is higher for staff with less than two years' service.

4.5 Positively, exit questionnaires showed there had been slight improvements in the number of happy leavers in the last six months (50%) compared to the last two years (47%). Leavers who would recommend working at the Trust in the last six months was 65% compared to 62% for the last two

years. 69% of leavers in last six months would return to work at the Trust, compared to 68% in last two years.

4.6 In addition, time to recruit is decreasing (to 66.6 days versus a target of 70 days) and there are improving roster approval times (although still below target). and decreased use of temporary staffing.

4.7 The use of temporary staffing is decreasing. A Safe Staffing Review in 2024 identified the need for 200 additional clinical staff for inpatient services, and the Trust secured an £8 million investment into inpatient staffing (on a recurring basis) in 2025. This did not include specialist services, including AFS. A later review in December 2024 led to additional funding for AFS. While this is very positive, we understand that the impact of this additional staff may not be felt on the ground, as many wards had historically been staffed to an "enhanced number", and this additional funding had funded the existing 'excess'.

4.8 The Safer Staffing Report to the Board now includes this data in a transparent and open way and notes the difficulties the rapid expansion of the nursing workforce has caused. Fill rates are reported by Care Group, with care hours per patient per day and use of temporary staffing. The report includes narrative which provides further context. For example, for adult forensic services (AFS), the challenge of staff unable to carrying out restrictive practice duties on a permanent basis is highlighted, along with sickness data.

4.9 There has been an ambitious and overall successful recruitment campaign following this. More than 100 international recruits have started at the Trust, along with 50 support workers and a further 37 registered mental health nurses.

4.10 In our fieldwork we heard that the new recruits had been welcomed to the Trust, and a thorough induction programme had been delivered, particularly for the international recruits. However, as the Trust had implemented a central recruitment approach, which recruited a number of staff with little or no experience within their speciality this had put an increased burden on experienced staff to supervise and mentor new recruits, with little or no experience within their speciality.

4.11 This was particularly evident in Riverside where we heard from both experienced and new staff of the difficult situation this had created. Examples given to us included:

- Internationally trained staff who had little or no experience in Mental Health and who were having to understand issues such as the Mental Health Act and Mental Capacity Act, and safeguarding. For some this was an overwhelming challenge.
- As well as new recruits, the unit had been shut to admissions for nearly three years, which had created a stable community where staff had been able to relax some of the restrictive practices. The reinstatement of new admissions, unknown to the service, and in an acute presentation of their mental distress was a new experience for many staff. This had led to tensions and disagreements between the level of restrictions required to safely manage the unit.
- The task of supervision and support was falling on a small number of experienced staff who themselves felt under enormous pressure to support staff whilst delivering safe care. This extended to understanding and acting on the side effects of medication, having to consistently be a member of the emergency response team, and of authorising (or refusing) leave requests from patients.

4.12 These issues were known and acknowledged by Board members, and the practice of central recruitment stopped during 2025. While this recognition and action is positive, there is at present no clear plan for addressing this gap in experience, and its impact on resource.

4.13 September data reported to the Board and / or People and Culture Committee shows that:

- Supervision has only recently begun to show signs of improvement, at 80.3%. Supervision rates had fallen slightly to 76% for line management and 72% for clinical supervision against a target of 85%. The People Metrics report includes further detail by service; in forensic services, supervision was reported as 81.3% at July 2025 (which has increased from 58% in 2023) and appraisal at 86.6%. For supervision, Corporate Affairs have the lowest rate at 26.7% with Talking Therapies the highest at 90%.
- Appraisal rates were at 78.9%, against a target of 85%, although again, there is a broad range of performance within this headline figure: (31.1% in Corporate Affairs up to 90.8% in Talking Therapies).
- Mandatory training rates are included.

4.14 We also heard concerns from staff about the number of colleagues unable to complete and undertake prevention and management of violence and aggression (PMVA) duties. The Executive were aware of the issue of 'disability passports' and were starting to address it. This information has also been reported to the Board. PMVA training compliance is at 70% (as of September 2025).

Systems to ensure that staff are encouraged to speak freely and that they are listened to

4.15 The Trust has reviewed and enhanced its offer around freedom to speak up (FTSU) and improvements can be seen within the staff survey. Actions have included;

- the appointment of two whole time equivalent guardians
- quarterly reporting to the Board
- a network of FTSU champions
- an anonymous report via a button on the Trust intranet homepage
- an e-learning package (90% compliance achieved) which is aimed at all staff within the Trust, including non-clinical staff.
- FTSU Management and Champion training, aimed at those staff who had volunteered to be FTSU champions within their wards and departments and core leaders within the Trust.

4.16 An internal audit of FTSU in 2024/5 gave ‘moderate’ overall assurance, noting some similar themes were recurring, and that documentation was not always consistent.

4.17 We heard from staff that they found speaking up easier than previously, but there continued to be concerns about the capacity of the organisation to respond rather than just listen, and there are still high levels of staff reporting reprisals because of speaking up. The Trust noted this and it is hoped ongoing work about the development of a just and restorative culture will start to address some of the residual issues within the Trust.

4.18 Positively, there is now clearer and more transparent Board reporting on FTSU, which is received quarterly. Recent Board reporting in this area shows that, of recent ‘speak ups’, 80% of cases had a constructive outcome and 96% of colleagues would speak up again. However, they also report there has been an increase in colleagues reporting perceived repercussions because of speaking up, and mixed feedback regarding the organisational culture. The report includes useful benchmarking data, which shows that some categories of concerns (including values and behaviours) raised by staff is higher than the national average.

4.19 The FTSU Guardian has established monthly meetings with the Executive Directors to review cases and themes. We heard of a strong executive commitment in this area.

4.20 Many felt that this improved monitoring was positive but wanted to ensure that the Trust leaders particularly focussed on compassion and kindness. This was described most palpably in the context of proposed organisational changes which appeared to be a source of considerable anxiety for some people we heard from.

Staff have the right knowledge, skills, supervision and mentoring to perform their roles

4.21 We were told that a training needs analysis had been completed for nursing staff and this had resulted in a £331k investment into a clinical skills team. This new team has been focussed on the delivery of:

- clinical induction for all staff (2 weeks)
- observation skills training
- the development of 'booster' sessions; there are sessions available with a focus on clinical skills required within the ward environments. These include: therapeutic observations, relational security and boundaries, and other relevant clinical skills.

4.22 There has also been significant investment into leadership training for the ward manager/matron group of staff which was well received by the staff that we met.

4.23 As described above whilst this training had been well received there remains considerable concern about the need for many of the new staff to work under high levels of close supervision and guidance. This was becoming increasingly evident in Riverside which is only now reopening to new admissions. It is likely that that, as admissions rise, this point will become more acute. The unit will need to be closely supported at this time.

The systems to ensure that staff health and wellbeing is supported

4.24 The evidence in this area was weaker. It appears that several disparate initiatives have commenced, but it was unclear how priorities and resource have been determined, or what their intended benefits are. Activities we saw included:

- The adoption of the 'Pleaz' app which encourages deskbound staff to undertake exercises at their desk periodically. The data shows a low and deteriorating uptake from GMMH staff.
- The development of 'menopause cafes', with four confirmed dates throughout the year.
- The appointment of several health and well-being champions who have been trained in holding health and well-being conversations.

4.25 Two of the current Care Groups also have full time well-being champions embedded within the team. There is an aim to centralise this work under a Trust-wide team, and a fixed term post has been appointed to undertake this work. Where local wellbeing staff are in place, these appear to be highly valued, and there was a concern that centralising this work would mean losing those colleagues.

4.26 A Trust-wide Health and Wellbeing Stakeholder Group was in place, however this was disbanded in Summer 2025 due to low attendance. A new Staff Wellbeing, Retention and Culture Group (which has a similar remit to its predecessor) will start to meet from December 2025, and will report to the

People and Culture Oversight Group. It is important that the work of this group has sufficient profile and senior support.

Residual recommendations

4.27 A start has been made on all the elements of this recommendation but by solving some problems new ones are emerging which need careful monitoring. The Trust needs to continue to act in a planned and purposeful way against all parts of the recommendation and monitor the changes made for their impact (planned and unplanned).

4.28 We also identified some further learning opportunities:

- to address the emerging divide between the newer, less experienced staff and those who have worked in the Trust for many years, or are more experienced.
- to monitor closely the effect that new admissions have on the current stable community, and the risks of managing clinical presentations which will be new to many staff.
- to ensure that all key metrics are reported to the People and Culture Committee, including Immediate Life Saving training compliance.

Recommendation 5: Estates

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. Within the first year: • The Trust Board must assure itself about the quality of its estate and safety within it.	
Assurance rating for this recommendation	**4**

Key findings

5.1 We scored this recommendation as 4: This rating should not be read as assurance on the *quality* of the Trust's estate (which was not our original recommendation) rather as assurance of improved oversight. The Trust has undertaken a review of its estate, and improved systems to monitor and respond to maintenance issues. There is now a clear process for ranking wards and departments, an updated process for reporting faults, and for the monitoring of cleanliness standards.

5.2 The focus should now be on ensuring that this work leads to the Trust having high-quality, clean and therapeutic environments across its estate.

5.3 We note the short-listing of the new North View building for an external award along with the Capital and Estates team and the catering team.

5.4 This chapter sets out our findings in relation to each of the component parts of Recommendation 5.

Assurance of the quality of its estate and safety within it

5.5 The Director of Capital, Estates and Facilities is responsible for ensuring that GMMH has a capital programme in place which assures a safe and therapeutic environment across the Trust' s services to ensure that the environment is safe and therapeutic. They are also responsible for ensuring that there is performance monitoring of the maintenance of estates.

5.6 The Estate Strategy (2022 - 2027) has been aided by a set of Estates Strategy Year 3 Deliverables, with refocused objectives based on learning from the previous two years and any changing priorities: The over-arching aims remain unchanged with an increased focus on monitoring. Year 3 plans were updated to include:

- improved oversight and monitoring with the introduction of the Built Environment Healthcheck, that combines a range of building specific compliance and performance data into a dashboard.
- embedding the use of environmental auditing.

5.7 The Trust has developed a comprehensive 'Built Environment Health Check' which brings together key infrastructure-related data at an individual building level to provide a rounded view of the 'state of the estate'. This provides a temperature check on estates performance and potential early

warning of emerging issues such as backlog maintenance, inpatient bedroom audits, environmental assessment audit results, catering audits and food hygiene scores and number of call outs.

5.8 The checklist we reviewed from October 2024 highlighted the following areas for priority works:

- The Riverside Centre had £12,907,000 outstanding on backlog maintenance.
- Environmental audit scores were lowest at Anson Road (79%). There were no actions or comments on the checklist to state what the planned actions were.

5.9 Other key actions undertaken since our original review have included:

- A campaign to raise awareness 'spot it, report it, we're on it.'
- The assessment of all seclusion suites, with plans agreed for refurbishment where needs were identified across the Trust. The number of seclusion rooms were included on the environmental checklist and the environmental audits.
- Reduced environmental ligature risk: In 2024, the Trust adopted the tool and methodology provided by the CQC[8], which clearly identifies what is required in relation to the built environment with a focus on minimising all environmental risks where possible. The tool also identifies all other aspects, such as therapeutic engagement, skills and staffing and technology as way to mitigate risk. These formed the capital works for 2025 - 26 and the list included actions needed to reduce risk across the Trust.
- A door replacement scheme to reduce ligature and fire risk with 96.35% of batch 1-4 doors (high priority) completed and 15% of batch 5 and 6 doors (lower priority) replaced as of June 2025.
- Employed monitoring officers and enhanced monitoring and reporting.
- Self-assessment against the NHS premises assurance tool[9]; This demonstrated year on year improvement and the internal processes reviewed by an external Trust, to provide assurance.
- Increased use of PLACE assessments[10], which must include at least two patient assessors. Improvements in satisfaction rates for the Trust were seen in all areas in 2024 compared to 2023, which reflects the national picture. Results published by NHS England in February 2025 were:
  - Cleanliness: 99.16%
  - Condition, appearance and maintenance: 96.32%
  - Dementia-friendly: 95.31%
  - Disability-friendly: 97.19%
  - Organisational food: 98.03%
  - Overall food score: 98.35%
  - Privacy, dignity and well-being: 98.39%
  - Ward food (food tasting): 98.64%

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[8] Ligature point recording template - Care Quality Commission
[9] NHS Premises Assurance Model NHS PAM 2025
[10] PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

5.10 Since our last visit to the Trust, Park House in North Manchester has been replaced by a brand new building, North View. We did not visit the site but note that the North View Project Delivery Team won the Health Estates and Facilities Management Association (HEFMA) HEFMA Project of the Year Award.

5.11 The Infection Prevention and Control Annual Report 2024 - 2025 was presented to Board in September 2025 with an assessment of providing substantial assurance. The Trust defines this as "*We are assured, but additional steps can be taken to gain more assurance*." Training rates for aseptic technique were below target with 67% of staff completing e-learning and 26% having competency assessments for aseptic technique in place. There were other areas of partial compliance. This report had been received by the relevant committees before review by the Trust Board. This is a 'live' example of improved oversight. In Q1, 2025/2026 performance for aseptic technique had increased to 76.4% for e-learning and 44.1% for competency.

Residual recommendations

5.12 The focus should now be on ensuring that this work leads to the Trust having high-quality, clean and therapeutic environments across its estate.

Recommendation 6: Governance

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. Within 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.	
Assurance rating for this recommendation	**2**

Key findings

6.1 We have scored this recommendation as a 2; there has been significant progress in some of these areas, which have been implemented in a considered and supported way, although it will take time for their impact to be meaningfully assessed. Evidence in relation to other aspects of this recommendation is weaker, and there is no evidence that the Trust has sought to implement a structured quality management system.

6.2 It is important within this section to reference the significant changes in the Executive Team and wider Board's membership. Almost the whole executive team is new, as are a significant proportion of the non-executive directors. Such changes in a Board's membership are likely to have caused a loss of momentum, and a subsequent need to ensure that change is managed in a way which helps colleagues to engage in the new ways of working required. We also describe the significant revisions to the Improvement Plan, partly because of the Trust being placed in Segment 4 of the Oversight Framework, at Chapter 8.

6.3 Alongside this, there is an operational restructure underway, as the Trust moves from five to four Care Groups. This has led to some further issues, including formal HR processes, which have required a slower pace to work through.

6.4 This chapter sets out our findings in relation to each of the component parts of Recommendation 6.

Governance framework and escalation/information flows

6.5 A new governance framework has been designed and was launched in May 2025. This focusses on setting out clear accountabilities for the organisation across four 'tiers', from services up to committees and the Trust Board. The structure we have seen makes sense and is reflective of models we have seen to work well in other NHS Trusts.

6.6 Importantly, specific thought has been given to the principles and values which are needed to make this new model work in practice, in acknowledgement that the right processes alone will not enable a healthy reporting and escalation culture. Eighteen principles have been set out, which include: psychological safety, accountability, consistency and ownership. We heard that a significant focus of this work has been in engendering more of a two-way dialogue between Trust leaders and staff, with a focus on mutual understanding, accountability and support. Senior leaders we spoke to agreed that there is mostly a more collegiate way of working with Board members.

6.7 There is a defined Executive Escalations Process which sets out how specific events are to be escalated to the executive. It includes checks that external agencies have been or will be notified. There was no opportunity for us to understand if the relevant staff were aware of this expected process.

6.8 The scope of our work also did not include a review of how reliably reporting systems are used. We did, however, hear a small number of concerns in this area. The Trust's risk and incident management system was reported to us as being 'clunky' and we understand that a steering group is in place to improve its functionality, including for actions linked to risk management.

6.9 There has been a consistent programme of Board development in support of all this work, although given the Board's newness, this is likely to remain an area of priority. Similarly, Care Group development activities have been in place since June 2024. However, the restructure has meant that not all Care Groups have implemented the new governance structure and are working with their legacy processes. It will be important to shift to a standardised way of working as soon as possible, and ensure that Care Groups are supported to embed the new processes effectively in each of their areas. A Quality Governance & Accountability Framework has been drafted to help this, but it is unclear if it has been formally launched and is in active use.

6.10 An Operational Oversight Group (OOG) has also been established, in part to ensure closer working between executive directors and services. The purpose of this forum is extremely broad ranging and includes: quality of care, risk, operational priorities, finance, digital, and some areas of the workforce agenda. Agendas are rotated so that one week of the month there is a quality focus. This is understandable so that the meeting is manageable, however it will be important to look at quality and safety matters in the context of other pressures the Trust is facing, so that honest conversations can be had about competing pressures and potential solutions. Exceptions from this forum are reported to the CEO-chaired Integrated Performance Group.

6.11 The Trust recognises that further work is needed to embed this framework in practice. Trust leaders told us that (we agreed with their assessment):

- Ongoing work is needed drive a listening and learning culture at all levels to ensure that the right information is consistently reported and acted upon.
- Further dashboards are in development to support the joining up of issues, trends and to identify themes for improvement.
- There is significant scope to incorporate more experts by experience in the Trust's governance structures, such as by appointing Patient Safety Partners with lived experience of using mental health services.

6.12 Some staff closely involved in the day-to-day delivery of the Trust's corporate governance work have received external training, for example, on effective minute taking and writing high quality reports. This is often an overlooked area in making a governance system work effectively, and it is positive that this support has been provided for staff. Feedback about these courses was broadly

positive. We note that ideas for organisational development support have been identified to support these governance and oversight arrangements, but it is unclear if these will be progressed and, if so, when.

6.13 In addition, there is still significant work to do on risk management. Key issues include: staff understanding and awareness of risk management and their responsibilities in relation to this, articulation of risks, the use of InPhase to record actions, and the appropriate scoring of risks. These elements are currently perceived as something 'separate' to the everyday work of managers, rather than embedded into the Trust's day-to-day workflows. As a result, in June 2025:

- 53% of open risks were aligned to Strategic Objective 1 - Best Care Every Day; the most frequently occurring risk topics were patient safety, staffing and patient experience. Around half of the Trust's corporate risks are allocated to the Chief Nurse.
- 69% of open actions were overdue, although this is on an improving trajectory since May 2025.
- 12% of open risks were scored as extreme.
- 38% of open risks do not have an action assigned to them.

6.14 There is an improvement plan associated with risk management, and additional training has taken place. However, resource in the corporate team is very low, and there are ongoing issues with the use of the Trust's new risk management system, InPhase which may also be hindering improvements.

6.15 Since our original review, the Patient Safety Incident Response Framework (PSIRF) has been implemented more fully across NHS Trusts nationally. GMMH sent us a significant batch of evidence as assurance of their approach to implementing the PSIRF, such as: policies, SOPs, templates and staff guides. Safety culture is key to the successful implementation of PSIRF and ultimately learning from patient safety events. Given the culture improvement journey the Trust has embarked on, we found scope for some of these key documents to be more explicit in this area, for example the role of managers in promoting an open reporting culture, or psychological safety.

Systems to scan for quality concerns

6.16 This is an area in which we saw several examples of positive progress since our original review.

6.17 Board-level reporting on quality of care is now strengthened. Quality is the first domain reported in the Performance Report and we noted that:

- There is a helpful executive summary, clearly outlining risk areas and notable performance to celebrate. The key messages for each area reported are visible at-a-glance.
- The use of data has been balanced with explanatory narrative for each area.
- Reporting is more transparent and we saw several examples of concerns clearly highlighted. Statistical process control has also been adopted to highlight where action is required and where concerning variation is present. Recent examples have included:
    - incidents with safeguarding concerns identified
    - inpatient falls resulting in harm
    - medication incidents
    - violence and aggression incidents towards service users resulting in harm.

6.18 The report could be improved even further if links to financial, operational and workforce pressures were more explicit so that there is a transparent picture of competing pressures and how relevant decisions may impact on each other (particularly if there is a cost pressure associated).

6.19 We noticed that not all these areas of good practice were reflected in the equivalent Quality and Safety Committee report where narrative to explain the data presented is often missing. This means that areas of poor performance are neither always accounted for, nor is it clear what improvement actions are being taken. Some metrics also appear incomplete, particularly relating to impact/outcomes; for example, the number of complaints received and number acknowledged within three days is reported, but not complaints closed within agreed timeframes, proportion of complaints upheld/not upheld, and patient satisfaction with the process.

6.20 It is important that Board members can corroborate and test the assurance they receive in papers with visits to services. This also enables boards to understand what it is like to receive care at and work in the Trust which they govern. We received the reports from the Board's programme of visits to services. These should include both executive and non-executive directors, governors and local staff. The programme covers a wide breadth of services, although some areas receive more visits than others. The approach to Board visits was refreshed in April 2025, and non-executive directors' input into these has since increased. The outputs of these visits are now reported to the Executive Leadership team, with themes and any improvement actions identified. The latest report highlights:

- scope for more visits to the Salford, Trafford and Talking Therapies Care Group.
- a need to review the feedback process from the visits, including sharing this with the Care Group leaders and local managers.

6.21 Since our original review, a weekly 'Quality & Safety Surveillance Huddle' has been implemented, through which managers and leaders with key responsibilities in this agenda meet to share intelligence from their areas with relevant colleagues. This provides a key opportunity to join up risks in relation to, for example: incidents, complaints, compliance and safeguarding. We saw a draft SOP to guide this process, but it is unclear if this has been taken forward and the lead for this work recently left the organisation.

6.22 We heard examples about how this process had been used to trigger Quality Reviews (sometimes referred to in documents sent as Quality and Safety Visits, or Clinical Assurance Reviews), for example, at Laureate House. This process was introduced in March 2025, and is effectively a structured visit to services to review the quality of care against set domains, namely:

- Organisation and management
- Infection Control
- Environmental Safety
- Medicines Management
- Safeguarding and Safety
- Service user and carer engagement

6.23 There is typically executive attendance as part of these reviews, whose outputs are reported to the Quality Committee. There has been significant focus in reviewing as many inpatient services as possible to seek assurance about overall quality of care within these areas. This process is positive, although we found that the resultant reports could sometimes be clearer. For example:

- Transparency around how scores have been ascribed for domains which have not been assessed; in some examples sent there were lots of ‘not assessed’ statements, with no clarity as to why this was the case (but compliance scores still being reported as 100% in these areas).
- Other examples had scores which appeared to be incongruous with what had been reviewed in practice.
- Service user and carer engagement has almost consistently been the lowest scored domain. There could be a clearer expectation about how much service user feedback must be sought to generate improvements. Linked to the above, intentions to use more experts by experience in support of these visits will be helpful in this regard.

6.24 Within inpatient services there is a Safety Matrix audit tool, through which each month, every ward is asked to review five current patients and five recently discharged patients. These are selected at random by the person completing the audit. The results of these audits were not shared with us and staff told us that these felt repetitious. We note that the proforma is very long, and looks at 17 areas, including: restrictive practice, handover, care plans and the quality of the record. It is unclear how this information is used in some of the processes referenced above, such as the Quality Visits or surveillance huddle. It is possible that there remains scope to better triangulate and more effectively use all the available information to understand overall quality of care, and emerging areas of risk.

6.25 Linked to the above, Safer Staffing dashboards now also include data on bed occupancy, complaints, staffing levels and incidents. These are provided to Care Groups to help leaders to identify potential hot spots in their service. This is a positive improvement from the time of our original review, although we could not ascertain how this data is used locally to identify potential services in distress.

Resourcing of governance functions

6.26 Our original concerns in this area related to the resource of key governance functions, including safeguarding. An initial review of structures within the Chief Nurse’s portfolio has been undertaken, with additional resource added into roles involving service user co-production for example. We heard that the Board had been supportive in ensuring that the incoming Chief Nurse had the right structures in place to make the necessary improvements.

6.27 Since our original review, the safeguarding team establishment has been increased by six posts. Two of these have been appointed to, but staff have not yet commenced in post and there are also some temporary arrangements in place to cover a member of staff on maternity leave. The evidence we were sent in this area was not always helpful in determining if the current resourcing models are appropriate for the needs of the Trust. For example, several job descriptions were shared, but it was not always clear if these roles were filled, or filled with trained, qualified and supervised staff. It is also unclear how the requirement for additional resource was measured, and we cannot see evidence of any capacity and demand analysis having been undertaken, or considerations of caseload weighting or complexity (either within safeguarding or other quality governance functions). This may be material, as the recent annual safeguarding report (September 2025) provided only ‘moderate assurance’ to the Board.

6.28 As at March 2025 data, the backlog for safeguarding referrals in the Trust had been cleared. This is a positive improvement from the position at the time of the ICB’s review in Spring 2023, although the Trust has not hit the target for safeguarding training for staff since September 2024.

6.29 We heard that an experienced Risk Manager has recently left the organisation, and noted that a senior interim individual who had implemented several of the oversight changes described in this

section has also returned to their substantive post, external to the Trust. The Trust will need to be mindful of sustaining pace in these key areas.

6.30 Work remains ongoing to identify what resource already exists within the organisation; for example, what complaints roles are held within Care Groups, and how best to use this expertise. A key comment in this area was:

"It's not always about the numbers of staff; it's also about getting the accountability and governance right."

6.31 We understand that there will now be a period of monitoring under the new governance framework, before making further changes to governance-related structures and roles. We agree that this is a sensible approach.

6.32 Finally, we were provided with several policies in relation to quality governance. A number were draft, some had taken several months to launch after their ratification, and the safeguarding policies had not been updated to reflect the current structure. The Chief Nurse has implemented a process to review and rationalise all Trust policies and SOPs.

Quality management system

6.33 No evidence was submitted in relation to this area. None of the senior staff we spoke to about this were aware of plans to progress this recommendation. We also heard perceptions that the Quality Improvement function (a key component of a quality management system) continues to be under-resourced.

Residual recommendations

6.34 All elements of the original recommendation should be implemented. Where components have been addressed, these should be kept under review to ensure that they are having the required impact, and enabling the necessary improvements over time.

6.35 We also identified some further learning opportunities in relation to:

- Developing an equivalent Quality Review process for community services.
- Understanding if any information collection requirements are duplicative or no longer add value.
- Ensuring that intelligence gathered across the Trust is triangulated to 'tell a story' and inform decision-making (across quality, finance, workforce and operational domains).
- Ensuring that the (draft) Quality Governance & Accountability Framework is formally launched and fully implemented in support of the new governance structure
- Incorporating experts by experience in the Trust's governance structures, building on the plans to appoint Patient Safety Partners with lived experience of using mental health services.

Recommendation 7: Edenfield

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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.

Within the first 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.

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Key findings

7.1 We have scored this recommendation as 2: The Trust and Riverside Centre have made significant progress towards this recommendation. Clinical models have been developed but are not yet fully implemented. Staff have been recruited but there is still work to do to ensure that care is delivered by multi-professional teams which is consistently effective and safe. This was acknowledged by staff working within the service, the senior management team and the Trust Executive. There are numerous recently approved Trust strategies and plans that are yet to be fully implemented and these will impact on the quality of service at Riverside going forward. These include, for example, the People Strategy and Nursing Plan.

7.2 Following assurance processes undertaken by NHS England's Regional Specialised commissioning team, NHS Regional Executive team approved the re-opening of forensic services to admissions. Cognisant of the challenges and the work still to be done, this was done in a staged manner: male low secure services reopened in January 2025, followed by male medium secure in June 2025 and finally the female services in August 2025. We heard from service management teams and clinical staff that this had gone well.

7.3 The service has made significant strides in trying to increase the numbers, capability and stability of the workforce but there is further work to do to achieve this.

7.4 Since our last report, there have been some concerns about the quality of care. These have been highlighted in the Regulation 29A the organisation received about adult forensic services in June 2024, findings from a CQC Mental Health Act (MHA) visit in March 2025. See also 7.17. At the time of writing, the Trust is awaiting its report from a CQC visit to Riverside in Summer 2025.

7.5 Whilst the interim executives worked to stabilise the Trust, the permanent team have provided more consistency and focus on their recovery. The current plan is relatively early in its journey with new strategy and training moving from ratification to implementation currently. We heard that the challenge and support the executive team now provide to Riverside is valued and giving clarity to their recovery journey.

7.6 The additional corporate posts in quality and safety roles have been welcomed by Riverside. We heard from staff on the wards that these changes are resulting in ward staff feeling more supported both through their supervision but also practically when wards are more challenged. They also provide a clear message to the service of the importance of nursing in delivering forensic care.

7.7 The success and challenges of the Trust's ambitious recruitment strategy were described at Recommendation 4. The challenges of central recruiting, which has now stopped, were described by staff across the service and we heard examples of staff arriving into the service with no knowledge of forensic mental healthcare, or the type of work required. Whilst some people have really embraced the opportunity to learn and enjoy their new environment this is not always the case. Staff described some being less motivated, and that this was resulting in issues with reliable and safe care (described below).

7.8 This chapter sets out our findings in relation to each of the component parts of Recommendation 7.

Clinical models for forensic care

7.9 The Trust has developed a proposal for creating safe, therapeutic, sustainable services. This was done in consultation with service users and carers, staff and commissioners, and finalised in November 2024.

7.10 This proposal describes a long-term model for delivering excellent forensic care, and a phased approach to achieving this.

7.11 The plan recognises the need to focus on opening its inpatient services again safely and stabilising these, before moving on to transforming its community forensic offering.

7.12 The later focus on community services aspires to reducing the number of admissions and readmissions into the service, expedite discharges and reduce length of stay. This plan is still early in its delivery.

7.13 The Recovery College, one of this service's highlights, continues to function and grow. During our visit we saw a range of vocational opportunities being offered in the Recovery College and in the site café. Patients we spoke to value these opportunities and the broader range of rehabilitation that enhance their recovery and future reintegration into their communities.

Systems that deliver and measure, high-quality care and a positive patient safety culture. Use of data and intelligence for meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents

7.14 Significant advances in informatics have been made; a comprehensive set of metrics have been developed and are monitored centrally and within Care Groups. These support an improved understanding of the quality and performance at Riverside. These metrics include complaints and

concerns, incidents, restrictive practices and safeguarding. This work has been developed in collaboration with NHS England's Making Data Count and is making use of run charts and statistical process control charts, this work is being spread down to the care groups. Run charts are accompanied by an analysis of what the data shows. This work is relatively new and there is further embedding to be done to ensure that this information is used effectively across services. We heard that the Integrated Performance Group (chaired by the CEO) has been helpful in this regard.

7.15 Adult forensic services (AFS) have a targeted plan that addresses ward security and patient safety and reports directly into the central assurance processes. This is currently reported as providing significant assurance. Incidents regarding ward and relational security are analysed in the adult forensic service health, safety and security meetings and there are weekly security audits to monitor compliance to AFS security measures. This also includes Safeguarding, for which there is now increased corporate support and resource (see Recommendation 6).

7.16 For information to be used effectively to manage safety, there must also be a culture of psychological safety. The management team, brought in to manage the service after the Panorama broadcast, have worked hard to foster this. Most staff we met with at Riverside acknowledged that they are working hard to role model this to staff. This has also been reinforced by Trust leadership and in Trust-wide initiatives (for example in the work on incivility and freedom to speak up systems referenced at Recommendation 3.) and their focus on creating psychological safety. This cultural shift has been fundamental in creating the conditions for this service to improve.

7.17 The service had a CQC MHA visit (to one ward) in March 2025. The resulting report cites inconsistencies in basic care processes, such as in the management of seclusion and risk assessment, formulation and safety planning. An action plan was developed to address these, which included developments related to, for example: estates, staff experiencing racism, service user empowerment and HOPES practitioners. These issues are discussed elsewhere in this report. We did not receive evidence of the impact of this action plan.

7.18 As outlined elsewhere in this section and wider report, consultant and wider MDT vacancies, as well as the level of new and inexperienced staff, have impacted in this area, For example, a lack of a full establishment of consultants across the service has meant that they are working across a number of services clinically and so have had less time to focus on building relationships and leading with the one or two wards/teams they will eventually have responsibilities. Work to continue developing this area must be a focus going forward.

Systems that support all staff work to effectively in multi-professional teams. This should include consideration of training, supervision, mentoring, coaching, reflective practice and wellbeing.

7.19 The leadership team has had some focus on teamworking, evidenced by an away day in June 2025, and staff described good team working within disciplines. Practice has changed within male medium secure wards and now supports a more consistent approach to team working, with consultants working to a maximum of two wards. This has not been fully enacted because of staff vacancies but will be adopted as this issue resolves.

7.20 Some wards have started developing practice that supports good multidisciplinary team working (MDT) working. These include using a Microsoft Teams channel across the MDT, which allows any member to get help and answers to questions in a timely manner and as new teams are developing, intentionally ensuring that all MDT voices are given voice and heard on the team, and intentionally managing the hierarchy within the MDT. These approaches need to be adopted across the site. Other practices are becoming more reliable, for example daily huddles ('plan my day') and care planning and this is improving the quality of care.

7.21 The latest National Staff Survey results for AFS showed some areas of improvement, but there were also some areas that had deteriorated since the last survey. We know that improvement progress is not always linear, but it is essential that the Trust continues to support the local leaders within the forensic services to ensure that the experience for all staff maintains improvement. Positively we note that in AFS, there have been significant improvements in supervision compliance. As of July 2025, this was 81.3% at July 2025 (up from 58% in 2023). Appraisal was also high, at 86.6%.

7.22 We heard some examples of tension within the MDT, particularly between the MDT and nursing team. For example, staff from therapies teams described how patients were not being adequately supported to get up out of bed and be ready for sessions off the ward and a lack of capacity in the nursing team to escort people to attend sessions off the wards. Both these issues resulted in patients missing therapeutic sessions.

7.23 Reflective practice has been instituted regularly; however, work remains to ensure all frontline staff complete the forensic skills training, with 50% reported as having attended by June 2025.

Systems that encourage staff to report quality concerns and improvement ideas

7.24 The Trust's new leadership is seeking to drive a more open and transparent way of working. The Trust's partners told us that leaders now proactively and consistently share concerns with them, since the appointment of permanent executives. The Chief Nurse provides weekly updates to the CQC and their demonstration of the Trust values was commented on often.

7.25 Some legacy issues from 2022 are still being felt and worked through. For example, some people who were working at these times at Riverside [Edenfield] expressed continued discontent and distress about the outcomes of the disciplinary processes. In particular, a perception that staff groups were treated differently. This is manifesting in different ways, for example: avoidance of Trust headquarters for fear of bumping into previous senior leaders, and a fearfulness about failing when testing improvement ideas or using restrictive practice, for fear of reprimand.

7.26 Staff survey results for AFS show a significant improvement against most questions from 2022 to 2023, however, there is evidence of deterioration in most scores in the 2024 survey (though this deterioration is not back to the very poor scores seen in 2022). Despite the downward trend, the score for encouraging reporting near misses (19b) was their most improved score and organisation ensure errors/near misses/incidents do not repeat (19c) has improved.

7.27 More concerningly, scores relating to staff experience of their immediate manager deteriorated significantly. It was surprising that there was not written analysis of these changes and improvement plans reported to the Care Group and Trust Board. In conversation with the management team, they felt that some of the challenges with the previous centralised approach to nursing recruitment may have contributed to some of the deterioration.

Systems to ensure that the lived experience and expertise of patients and families are central to the work of the service.

7.28 A central Trust Service User Council was established in February 2024, and efforts are underway to implement structures for service user and carer feedback within each Care Group, contributing to co-produced improvement plans. This has yet to spread across the organisation. Riverside has implemented patient and carer meetings, and minutes show concerns about care are being raised. For example, in relation to cancelled leave and activities due to staffing shortages. Elsewhere staff raised concerns with us about inconsistent patient representative attendance at this meeting, with

leave not always being facilitated to support attendance. This may indicate that this important activity is not being prioritised.

7.29 When we met with service users they reported an improvement in care; some still said there was room for improvement, particularly in relation to some staff attitudes and behaviours. Some carers we spoke to described the engagement staff on some Riverside wards as being excellent at responding and supporting them, but they had seen little improvement in involvement in their loved one's care. We heard of one experience of failing to compassionately engage with a family.

7.30 There is an overall Trust ambition to move to a co-production approach in working with service users, but this is still in its early stages. There is an opportunity for the service to look outside and learn from similar services who are further along this journey.

7.31 The staff survey for AFS show continued improvement and green responses from this care group to the questions that organisation acts on concerns raised by patients/service users (q25b) and care of patients is organisations top priority (q25a).

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.

7.32 The number of nursing staff working within the service has increased; typically, each ward will have at least two registered nurses per shift. The Trust has worked to reduce its use of temporary staff (to 2.6% against a target of 6.1%). We heard that the use of agency nursing staff at Riverside has been eliminated and the Safer Staffing Report July 2025 confirmed this. For July 2025, bank usage was 7.8% at Riverside. There were 22 unsafe staffing reports for the month, although no narrative provided around this in the report. However, staff still described being frequently moved between wards, and the drive to recruit nursing staff has not been without challenges as set out at Recommendation 4.

7.33 To mitigate this, the service has developed an induction programme and a forensic clinical skills programme. 100% of frontline staff were to have completed this training by October 2025. Re-opening the service is creating further opportunity to enhance skills as staff put their knowledge into action. On our field visit, a wider staff group expressed concerns some new staff had not anticipated the nature of the role or the clinical environment, and were reluctant to put some key skills into practice. Some staff said that they thought some newly recruited staff did not want to work in AFS and despite training did not appear motivated to put this training into practice. Another example we heard was that some staff did not always know patients' leave status when they brought them to reception. These issues are known to the senior team and executive and are being worked through.

7.34 Other issues with quality were reported to the Lead Provider Collaborative Oversight Group in January 2025. The minutes show concerns about how some staff are viewing the job despite messages to promote caring, honest and professional behaviour. The minutes describe these incidents being dealt with, and the importance of the ongoing work on culture and leadership on the unit and in the Trust. These issues were still being reported to us during our site visit in late August 2025.

7.35 The service values its dedicated staff member who focuses on wellbeing, and this individual is highly regarded. However, global majority staff continue to experience racism and current attempts to manage this were not having the desired results. We heard that some global majority staff thought that the Trust's BAME Network had insufficient capacity to influence change. Some colleagues also mentioned to us a lack of representative role models in the service and wider Trust.

Review of advocacy services in Edenfield

7.36 Riverside advocacy services continue to be provided by MIND; it is unclear whether this has been formally reviewed, per our original recommendation. There has been improved capacity for the advocacy service as resource was not cut when admissions were stopped. The service will need to be mindful of the impact on this resource if they exceed the 150 beds it currently supports and consider making necessary adjustments to ensure that the quality of the service is not diluted. Advocates are involved in staff training, they attend monthly AFS SLT meetings and weekly huddles with the professional and managerial leads from Riverside.

7.37 The service runs a monthly Patient Empowerment Group, which patients attend, and provide a quarterly report to the Riverside Senior Leadership Team. Advocates have played an important role in the new independent seclusion review system and are part of AFS Reducing Restrictive Practice meetings. This adds a further layer of independence to this process and should enhance the rigour of these reviews.

7.38 The September 2025 Board Performance Report stated that 87% of patients within the Trust had their rights explained to them within seven days of admission. Sentinel metrics for October 2025, reported that 80% of patients in AFS had their rights explained to them within seven days of admission.

Systems that ensure that the internal environment is clean, safe and fit for purpose

7.39 The systems to oversee the Trust's estate overall have improved (see Recommendation 5). At Riverside specifically, the internal environment has improved. During our visit, the service felt substantially more welcoming and open, beginning with the improved approach to Riverside, featuring updated signage and art installations at Prestwich site's entrance. The interior renovations now offer bright, well-appointed spaces for patients. Seclusion suites have benefited from significant investment, providing contemporary environments that allow patients greater sensory control and multimedia access.

7.40 The National Standards of Care Audit Dashboard were green across all standards for Riverside (April 2024-January 2025, which was the latest information available to us). There is a PLACE tracker now used, to monitor actions arising from patient-led assessments of the unit. The version shared with us had 968 overall recorded areas of concern (including historic), although most actions have been completed or are in progress. These actions include a variety of issues from changing light bulbs, repairing shower taps, chipped paint, issues with taste and texture of food to more extensive environment refurbishment.

7.41 New areas of concern do continue to be emerge, for example issues with drains identified on an MHA visit to Dovedale. A similar issue had been noted in December 2024 on Borrowdale. Whilst there remain issues to be solved, these are known about by the senior management team and plans are in place to manage them.

Residual recommendations

7.42 Building on the positive work already undertaken to move the service forward, all elements of our original recommendation need to be addressed and embedded

7.43 We also identified some further learning opportunities in relation to:

- The Trust has been collaborating with an external partner in a sample of services to pilot culturally sensitive approaches to advocacy. These approaches are rights based and anti-racist, and aim to support people from minority ethnic backgrounds access the care and support they

need, and challenge discrimination in care. Learning could be taken from this pilot to inform any future improvements to advocacy at Edenfield.

- Moving the service towards a co-production approach to its improvement. The service should consider contacting and connecting with other similar services who are further on this journey.
- The service has redesigned a new clinical model and is in the early stages of implementing this, the community model has yet to implemented and evaluated.
- The service has made a start to ensuring that the lived experience and expertise of patients and families are central to the work that they do. However, there is opportunity to significantly expand this. The journey could be accelerated by looking to other forensic services that are further along this journey
- There remains opportunity to improve how the multidisciplinary teams work together. Whilst team building work has been done within disciplines teambuilding across MDT teams must be a focus. This will help teams to understand each other’s roles in delivering high quality care, support teams to take more collective responsibility for care and to collaborate with each other more effectively when any of that team need additional support.

Recommendation 8: Improvement plan

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. Within 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.	
Assurance rating for this recommendation	**2**

Key findings

8.1 We have scored this recommendation as a 2. Several areas of this recommendation have been substantially implemented. There has been significant work to ensure that the plan is prioritised, achievable and (in many cases) measurable to assess its impact. However, since this recommendation was made, focus has shifted from the (as was) Improvement Plan to the new and more regulatory-driven Recovery Delivery Plan, which is targeted at improving the Trust's Oversight Framework rating. From our perspective, this has determined much of the Trust's approach to undertaking this work.

8.2 In response to the Panorama broadcast in 2023, the Trust produced a wide ranging and detailed 'Integrated Improvement Plan'. Our original report commented that this was largely focussed on transactional and short term matters, and needed much more focus on the cultural issues which our work highlighted. We understand that the (as was) Improvement Plan was not systematically reviewed in line with our original report, as suggested in the recommendation above.

Articulating the problems the Trust is trying to solve

8.3 In August 2024, the Improvement Plan was transitioned to a rebranded 'Recovery Delivery Plan', focussing on the key criteria set by NHS England to leave Segment 4 of the NHS Oversight Framework[11]. 'Exit criteria' were identified under the headings of:

- Quality and Safety
- Leadership and Strategy
- Culture

[11] According to the Oversight Framework, Segment 4 means "The organisation is significantly off-track in a range of domains."

- Governance
- Financial sustainability

8.4 There are 56 action areas in the plan. When we spoke to senior staff in the Trust, and its partners, we consistently heard of a need to prioritise these to make progress. Most commented that the previous Improvement Plan was unwieldy, and this has been a key focus of the new CEO.

8.5 This move, to focussing on Segment 4 'exit criteria'[12] has, by default, prioritised these actions at the expense of other demands. This must be considered in the context of the Trust's regulatory undertakings, as well as financial implications, for being in this segment and with the changes at executive level. As at September 2025, 31 of the 56 areas had transferred to 'business as usual' indicating that actions had been completed. The Trust agreed a deadline of March 2026 to 'exit segment 4'.

8.6 We understand that being in Segment 4 places a significant burden on the Trust and its leaders, and comes with high levels of pressure and frequent requests for assurance. Equally, regulators must assure themselves and the public that required improvements are being made.

8.7 The refocus on these exit criteria, however, has meant that the spirit of our original recommendation, i.e. building bottom-up and co-produced improvement plans with clinicians and service users at their heart, has not been a priority for the Trust and has been somewhat lost. As outlined throughout this report, the Trust is in the early stages of its service user and carer engagement journey, and work has begun in this area. In the next iterations of the improvement/recovery plans, there is now a clear opportunity to bring more voices into defining improvement priorities.

8.8 To oversee all this work, the Trust launched a monthly Recovery Delivery Group which first met in August 2024. This acts as the performance, governance and delivery function for the transition to 'Segment 3'. This forum reports to both the System Oversight Board and to the Trust Board who both receive regular presentations and updates progress. Oversight of the plan is also a key focus of the System Improvement Board.

Defining impact measures

8.9 A measurement strategy has been defined for all areas of the plan, so that its impact can be assessed. Some of these seem to be more meaningful than others. For example, there are detailed outcomes and expectations described in relation to actions put in place to reduce restrictive practices. In other areas, however, there continues to be a focus on inputs (such as the percentage of staff trained in a particular matter). Another example is care planning, in which there is an aspiration to improve patient involvement in care planning and of the quality of care plans, however, the measures of success are limited to care plans in date and compliance with audit.

8.10 Given the high number of actions which have been reported as complete (or transitioned to 'business as usual') it is key that there is proper oversight of the impact these actions have had.

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[12] The Trust was placed into Segment 4 of the NHS Oversight Framework. This meant it entered the National Recovery Support Programme and would receive mandated intensive support. In order to exit this segment, the Trust has to meet agreed transition criteria to leave the segment. In 2025/2026, NHS England changed the oversight framework. The Performance Improvement Programme replaced the Recovery Support Programme and there are now 5 segments with the most challenged organisations placed in Segment 5. GMMH is now in Segment 5.

Prioritisation and sequencing

8.11 We did hear on a number of occasions that a change in pace has occurred since the arrival of the permanent CEO and her new team. For example, a more focussed and rigorous approach has been applied to the Recovery Delivery Plan than the previous Improvement Plan and this has been well received by system partners.

Residual recommendations

8.12 Aspects of our original recommendation have not been implemented, in part because of the re-focus onto the Segment 4 exit criteria. In future iterations of the plan, there should now be a clearer focus on engaging the views of staff and service users. As before, prioritisation and sequencing will need to be considered as part of this.

Recommendation 9: Elsewhere in the organisation

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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.

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.

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Key findings

9.1 The Trust has made progress in its governance and oversight of key areas. This includes its suicide strategy and ligature reduction work. It is also providing more transparent and coherent information to the Board.

9.2 There are some areas where it is too soon to determine the impact of new policies and strategies. The area that has made the least progress is the independent review of community services by the ICB and this remains an area of concern.

Review of safety concerns and sustainable learning when people die unexpectedly

9.3 The Trust provided evidence setting out how it had strengthened the identification and oversight of unexpected deaths within inpatient services. This includes a Mortality Oversight Group, a weekly executive led meeting regarding serious incidents (including deaths) and improved reporting to the Quality Assurance Committee. The Chief Nurse chairs a monthly Patient Safety and Effectiveness group that reports to the Quality Assurance Committee. Data presented at this meeting is in a format that is easy to understand and is of a good standard. Learning events have been adopted for key safety themes to support improvements in safety.

9.4 The improvements set out above are an important response to the recommendations made in our original review, however as we state throughout this report, these governance processes are still

embedding and not yet fully mature. They are also contingent on the establishment of a healthy safety culture, which includes psychological safety.

9.5 Our desktop review found scope for improvements in safety oversight. For example, three deaths of people on leave from inpatient services had not been reported to the Quality Assurance Committee (QAC) in a timely way. We also noted that 84% of patient safety investigations are behind plan (as at September 2025). This poses a material risk to timely learning being shared back into services.

9.6 The Trust has developed a suicide prevention strategy, which sets out a clear aspiration for zero suicides, and recognises the complexities associated with this goal. The strategy states that it is informed by the Zero Suicide Alliance and other local and national guidance, and is underpinned by the new clinical strategy. It includes an analysis of GMMH suicide data and identifies that GMMH is one of ten trusts with the highest patient suicide rate for the period 2018 to 2020. It also states that there has been an increase in suicide rates across the population over the last 10 years in Greater Manchester. The associated Suicide Prevention Delivery Plan is overseen by the Learning from Deaths Group.

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.

9.7 As outlined at Recommendation 6, oversight of safety has improved through new structures and processes. Measures such as:

- The quality surveillance huddle
- Quality Review process (inpatient services)
- The integration of safe staffing data with incidents reported, and other key safety indicators
- The enhanced Integrated Performance Report

9.8 These are all examples of positive change which are leading to the timelier identification of risks. Not all of these have been embedded however, and standardised approaches to Care Group governance processes remains an important gap in the Board having a consistent line of sight into services.

9.9 We have seen evidence from a report on ligature reduction presented to the Patient Safety and Effectiveness group. The report sets out work in relation to ligature reduction. It outlines how the Trust has revised its ligature risk assessment approach in response to updated CQC guidance. The report also identifies further changes to training in relation to ligature.

9.10 The GMMH Quality Account (2024/25) more clearly and transparently sets out in detail the relevant information required regarding patient safety, including an acknowledgment about areas that have improved and areas that require further work. This includes a clearer and more transparent overview of patient deaths and patient safety incidents. This includes the Trust undertaking five learning events, including one on clinical risk assessment and inquests, what to expect and how they learn.

9.11 The Trust has undertaken a thematic review of 12 deaths by ligature. This found that the deaths were spread across several wards and were not limited to any particular ward or area in the Trust. The report identified some themes including:

- Documentary inaccuracies or omissions

- Observations
- Resuscitation
- Staffing and training
- Communication

9.12 The same report identified that, in 2022, the Trust accounted for a quarter of all ligature deaths in the country (based upon The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) data).

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.

9.13 We have seen reports provided to the System Improvement Board (SIB) that reference work undertaken by GMMH to analyse deaths across both community and inpatient services, and work to learn from these. We have been unable to identify how or where a decision was taken by the SIB about who should undertake the analysis. We have seen analysis on deaths presented to the relevant internal GMMH committees.

9.14 GMMH undertook two separate analyses of deaths, namely community deaths and inpatient ligature deaths. Data provided to us by the Trust regarding inpatient suicides identifies there have been 13 deaths by ligature within inpatient services between January 2021 until March 2024. The report identifies a number of learning opportunities and makes several recommendations to improve safety across in-patient services. We have been told that that there have been no further inpatient deaths by suicide on the wards since March 2024.

9.15 We were also informed that there have been four deaths by suspected suicide of patients while on leave from hospital from October 2024 to August 2025.

9.16 A review of community deaths between 1 April 2023 and 31 March 2024 was undertaken by the Trust. The report states that:

"looking at community suspected suicides there have been 89 deaths up to the end of 2023/24. It is important to note these figures may be amended throughout the year as inquests are heard and verdicts on deaths given."

9.17 The report concludes that the Trust's Suicide Prevention Group and the 'triangulation of information' will be reviewed in light of this analysis, and alongside the implementation of the suicide prevention strategy.

9.18 More recent data provided to this review on community suicides for current and former patients identifies that, from January 2023 to August 2025, there were 243 deaths. It is important to note that, until a coroner has concluded an inquest, deaths are not registered as suicides. This leads to data changing as there is often a delay between the incident and the coronial process completing. For example, the Office of National Statistics reported that in 2024, of the suicide deaths registered, only 38.7% of the deaths actually occurred in that year.

9.19 The Trust's suicide prevention strategy identifies that there has been an overall increase in suicides across Greater Manchester over the past 10 years. This is in contrast to national suicide rates reported by the Office for National Statistics, which showed no increase in deaths by suicide

between 2023 and 2024[13]. In England, an average of 26% people who die by suicide have been in contact with mental health services within 12 months of their death (National Confidential Inquiry into Suicide and Safety in Mental Health, 2025). It has been difficult to determine the actual number of community suicides across GMMH, as outlined above.

9.20 In our original review we made observations regarding learning from coroners reports and the Prevention of Future Deaths (PFD) reports. We have been provided with an analysis of this by an organisation who represent people with experience of using mental health services. This data suggests that has been a gradual increase in the use of PFDs for GMMH. We know that nationally there is variation in the use of PFDs by HM Coroners. However, it is essential that the Trust should routinely consider this important information as part of its commitment to learning.

Identify whether further independent assurance is needed in any services. We recommend that Community Mental Health Services are independently reviewed

9.21 The context of the above recommendation was various concerns expressed to the review team in 2023 regarding the quality and safety of community services. During our assurance review we have continued to hear concerns about community services, particularly within the Manchester locality. These concerns relate to various areas including waiting lists, the oversight of people on the wating lists and possible deaths associated with waiting for care. During the course of our work, we became aware of 628 patients in Manchester being treated under the under the Care Programme Approach who were unallocated to a care coordinator (figures as reported to the Community Mental Health Transformation Programme Board, August 2025). We also heard that proposed changes to community services were causing some concerns and anxiety across the organisation.

9.22 The ICB started work on commissioning this review in April 2025. However, it is concerning that there have been delays in progressing this recommendation, particularly in line with the issues outlined above. We were told that the delays were due to the Financial Undertakings that the ICB was subject to.

9.23 We were provided with the terms of reference for the review and were told that the organisation undertaking this work were selected through the established NHS England commissioning framework and they had the relevant mental health knowledge and skills. We were told that the review would ensure that it captured the voice of people with a lived experience, their carers and staff. We were also advised that the review would consider relevant safety data including deaths and waiting lists. We reinforced to the ICB the importance of this information being understood fully, and of hearing directly from people with lived experience of community mental health services. As this work remains ongoing, we have not seen its outputs.

Residual recommendations

9.24 The Trust should revisit the data provided to the review team regarding the number of community suicides to determine whether any further learning or actions are required. This information should be discussed by the Trust Board, Quality Committee and SIB as part of the ongoing assurance and recovery process.

9.25 The Trust should routinely consider the learning from PFDs and how this may enhance organisational learning. Other types of patient safety learning responses also need to be completed within agreed timescales, so that improvement actions can be implemented in a timely way.

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[13] In 2024 there were 11.4 suicide deaths registered per 100,000 people; a similar rate to 2023, with 11.3 suicide deaths registered per 100,000 people.

9.26 NHS England, together with the ICB and GMMH should discuss the review of community services and ensure that they are confident about the quality and safety of care provided to people, particularly those on waiting lists.

9.27 The ICB should ensure the review of community services is completed and that the findings and recommendations are shared widely.

Recommendation 10: System oversight

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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.

Within 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.

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Key findings

10.1 This recommendation is multifaceted, with several local and national stakeholders involved in ensuring its successful delivery. Overall, we have scored this as a 2. There has been progress in relation to some aspects of this recommendation, but other areas are less developed, and in a small number of cases, there is no demonstrable evidence of implementation.

10.2 In addition, since the original review was published, there have been significant changes in the political landscape of the NHS, which have been particularly felt in the organisations with responsibility for the oversight of quality and safety of care. Some of these include:

- May 2024 An independent review into the effectiveness of the CQC was announced.
- July 2024 A change of government and appointment of new secretary of state for health who announced a review of the NHS by Lord Darzi.
- July 2024 Review into the operational effectiveness of the Care Quality Commission: interim report published.[14]

[14] Department of Health and Social Care, Review into the operational effectiveness of the Care Quality Commission: interim report, July 2024

- September 2024 Lord Darzi's Independent investigation of the NHS in England was published.[15]
- October 2024 The final report of the operational effectiveness of CQC was published.[16]
- October 2024 CQC publish a review of CQC's single assessment framework and its implementation.[17]
- March 2025 Significant structural change announced with the abolishing of NHS England and its functions being integrated into the Department of Health and Social Care.
- March 2025 Integrated care boards (ICBs) asked to reduce their workforce by 50%. This also reversed the decision for specialised commissioning to be moved from NHS England to the ICBs in April 2025.
- July 2025 The government published its 10 Year Health Plan for England[18], setting out ambitions for the NHS over the next 10 years.

10.3 These national reports and announcements have significantly impacted on those organisations charged with oversight of health providers, and are likely to bring changes to structures, personnel and responsibilities.

10.4 Within this context, more progress has been made in relation to:

- better partnership-working between external agencies, so that information is shared and understood in a timely way to identify potential services in distress.
- 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.

10.5 We found less evidence of assurance in relation to:

- reviewing the assurance architecture for the oversight of GMMH and consider why this failed to identify workforce, culture, and quality concerns at an earlier stage.
- how the ICB reviewed 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. They had introduced a new mental health clinical effectiveness group, however, it was not yet clear what the impact of this was.
- defining why CQC's 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.

10.6 This section explains our findings against each component part of our recommendation:

Learning from Riverside [Edenfield] to improve oversight systems

10.7 We heard that communication between the CQC, ICB and NHS England had improved since the original review, and that the governance structures in place provided stakeholders with the opportunity to share information.

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[15] Department of Health and Social Care Independent investigation of the NHS in England, September 2024
[16] Department of Health and Social Care, Review into the operational effectiveness of the Care Quality Commission: full report October 2024
[17] Care Quality Commission, Review of CQC's single assessment framework and its implementation October 2024

[18] 10 Year Health Plan for England: fit for the future - GOV.UK

10.8 Work has been undertaken to review the assurance architecture for oversight of GMMH as a provider. However, it was not always clear how each organisation had used these reviews to reflect on what took place at Riverside [Edenfield], and to learn from this in the development of any new systems and processes to be assured that this would be picked up at a much earlier point.

10.9 The ICB has quarterly system quality groups which the CQC and NHS Specialised Commissioners are invited to. These strengthened relationships with partners have enhanced oversight and enabled earlier conversations about quality and safety. Other established oversight meetings continue to run, where all providers are discussed and stakeholders meet. There was also a group set up by the ICB to monitor all responses to our original review, but we heard that this was no longer running.

10.10 The ICB asked boards of local providers to reflect on the findings of the original review by considering how well their organisation would respond to a number of prompts. This has been followed up by the ICB and where good practice has been identified, there are plans to share learning.

10.11 In July 2024, in response to identified concerns, NHS GMICB agreed undertakings with NHS England in relation to four areas:

- Leadership and governance
- Financial sustainability
- Performance and assurance
- Quality of care

10.12 There were a total of 36 undertakings, and the ICB submitted an action plan. NHS England reviewed improvements in March 2025, and September 2025. The ICB is now compliant with 32 of the 36 undertakings with improvements against leadership and governance and quality with NHS GMICB demonstrating good quality governance assurance and oversight mechanisms.

10.13 The CQC told us that since our original review, their focus has been on reviewing their regulatory approach following two external reviews. The CQC has focused on their use of data, re-establishing specialist sector specific teams, and embedding safeguarding and identification of closed cultures in all its work. We heard this is ongoing work. We did not receive evidence of assurance in these areas.

10.14 Locally, the CQC operational team have developed a bespoke response to strengthen its oversight of the Trust. This includes a team of three inspectors who oversee incidents, the information that the Trust submits to comply with the imposed conditions, weekly updates from the Trust's Chief Nurse about incidents and regular meetings with the Trust. This was reported as working well with the Trust being more open and demonstrating a transparent approach to sharing. However, at an organisation level it was less clear how the original review had been acted upon at the time.

10.15 Nationally, NHS England has undertaken a significant amount of work to support organisations to measure what matters, and to identify who is responsible for looking at the early warning signs. These are focused on the risk of a closed culture developing. This is coupled with ensuring those with oversight responsibility know what actions to take when improvements are needed based on evidence of successful interventions. NHS England also highlighted the importance of using data so that early warning signs can be viewed through the lens of inequalities. NHS England have piloted the co-produced approach in 15 sites which aims to identify closed cultures and plan to share case studies and learning from the pilot.

10.16 The regional NHS England team volunteered to be part of a project strengthening oversight of performance.

10.17 NHS England has provided expertise to support the Trust and the lead provider collaborative function to develop their own oversight systems, and this has helped them have a more detailed understanding of the Trust. For example, support has been offered in developing their oversight of mortality. Minutes included in the GMMH July 2025 mortality review meeting pack show that regional NHS England colleagues were to be invited but the Trust were waiting for confirmation of names to invite.

10.18 We received meeting minutes for the quarterly contract minutes between the Provider Collaborative and the Trust for the last 12 months.

10.19 There was a strong focus on metrics with the provider collaborative identifying queries from the metrics provided. There was less focus on qualitative data, including feedback from provider collaborative visits, service user/carer and staff feedback.

10.20 The minutes for April 2025 stated that following the reopening of Lowry Unit, the low secure male wards, there was to be a quality review six months following the first admission. We have not seen this at the time of writing this report.

Appropriate mental health expertise within the ICB

10.21 In March 2025, all ICBs were directed to reduce their workforce by 50%. We asked the ICB about how they were assured that they had a sufficient level of mental health expertise to oversee mental health organisations. The evidence shared was not dated and did not include details of how the ICB was assured this was sufficient (in terms of quantity, seniority and level of experience). They provided a set of slides which described the purpose of the Greater Manchester Mental Health Partnership Board which is co-chaired by the ICB chief medical officer and the CEO of Pennine Care Foundation Trust. It did not detail how long the Board has been in operation, or any outputs.

10.22 NHS GM has a clinical leadership model that is embedded into the governance of the MH Programme. There are 10 Clinical Care Professional Leads (CCPL) who provide clinical oversight and expertise into the Mental Health transformation: these roles are part-time as the postholders have substantive roles in the mental health system. They are from a range of professional backgrounds.

10.23 These roles report to the NHS GM Clinical Director, Mental Health, and work closely with each programme lead. Each CCPL has a specific set of objectives set in line with the priorities of the MH transformation programme. We were told that these were regularly monitored through one to ones, team meetings and away days but did not see evidence of this. In addition to the CCPLs there is a lead clinician for mental health.

10.24 We heard that the establishment of the Mental Health Partnership Board and a clinical effectiveness group had improved oversight of mental health services, but we did not see any evidence of the outputs of these groups so are not able to comment on their effectiveness. Some service user groups told us that they were concerned that the same people were responsible for oversight at the ICB who had failed to identify the issues at Riverside [Edenfield].

CQC and closed cultures

10.25 Within the CQC, there has been work into improving their ability to identify closed cultures. The CQC piloted an Observing and Improving Cultures (OIC) Framework on nine wards in inspections in services which had previously been inspected and rated by the CQC. The pilot ran between

approximately August 2024 and January 2025. Due to the focus on recovery work in response to the recommendations of the independent review of CQC[19] [20] we heard that the CQC is now reviewing the OIC framework, along with the overarching review of their assessment framework, to see how this can be embedded as business-as-usual work moving forward. This is still underway as of October 2025.

10.26 The national NHS England Mental Health team has developed a new approach to identifying early warning signs that a service might be in distress, including the risk of a closed culture developing, and risks related to inequalities. This system describes the roles and responsibilities for responding to such concerns, and evidence-based action to take. The approach has been piloted in 15 areas, and there are plans to evaluate the impact of the pilot.

Partnership working to share concerns in a timely way

10.27 NHS England's oversight framework was reviewed for 2025/2026 and providers who were in Segment 4 of the Recovery Support Programme were automatically placed in Segment 5 of the Provider Improvement Programme (PIP). GMMH was therefore in Segment 5 of PIP when we undertook this assurance review. In December 2025, the Trust was assessed as making progress and therefore placed in Segment 4 of the oversight framework.

10.28 Until recently, the System Improvement Board (SIB) was the forum where the Trust and external stakeholders met to review the Trust's progress against the criteria to exit the Recovery Support Framework. This was established following the decision in October 2022 by NHS England North West to:

- to place the Trust in segment 4 [later segment 5] of the NHS Oversight Framework and enter the national Recovery Support Programme.
- to introduce enforcement undertakings with the Trust.
- oversee development and implementation of an improvement plan and associated support offer.
- approve establishment of an Improvement Board to oversee and co-ordinate the system response, development, and delivery of an improvement plan.

10.29 Its Terms of Reference detailed membership but not quoracy. It includes all stakeholders, and minutes of meetings show that there has been a consistent attendance from each body at a suitable level of seniority. We were told that these arrangements are supported by well-established working relationships.

10.30 A key focus of this forum was the oversight of the Trust's performance against the NHS Oversight Framework exit criteria. While the SIB was designed to ensure that there was a focus on the impact of outcomes, its minutes showed a focus is on exiting Segment 5 and could be strengthened by ensuring that the impact and experience of care by those receiving and delivering care was at the heart of the process.

10.31 The SIB has now been stood down at the Trust having been removed from Segment 5 of the PIP. This factor, alongside the planned changes within NHS England, the ICB, and those in the CQC mean that there is a risk that there will be a loss of organisational memory and effective working

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[19] Department of Health and Social Care, Review into the operational effectiveness of the Care Quality Commission: interim report, July 2024

[20] Department of Health and Social Care, Review into the operational effectiveness of the Care Quality Commission: full report October 2024

relationships and systems to share concerns. This risk is not unique to the Trust and we were told there was a transition plan in place.

Support from the system to the Trust to enable improvements

10.32 There is evidence of appropriate challenge within SIB. However, this forum was also described to us as an 'accountability forum' for GMMH; there may be scope for more collective support in the spirit of system working within this forum.

10.33 The SIB terms of reference include oversight of progress made against our original recommendations. We noted that, in practice, the focus of the SIB meant the committee discusses various matters germane to SOF 4 and this has resulted in the recommendations not always seeming to have a central focus to the meeting.

10.34 The issue of the burden of oversight, and duplication of meetings, was raised in several meetings. The regular oversight meetings of CQC with the Trust were extended to include a representative from the ICB to reduce repeating meetings.

10.35 There were some examples from 2024 of information still not being used proactively or in a timely manner to work in a supportive way with the Trust, make the best use of resources and pool available information. We heard that while organisations do discuss any emerging concerns regarding the Trust's services, there is not a joined-up approach to driving and pacing improvement actions. For example, there has been little discussion of the quality of care in the community, the recommended review of community services and recommendations which were for organisations other than the Trust.

Residual recommendations

10.36 Further changes are likely to take place in the regulatory and oversight landscape. These should be used as an opportunity to explicitly reflect on how what happened at Riverside [Edenfield] was not identified sooner. This learning should inform the new structures which are likely to be developed over the coming 12-24 months as NHS England is dissolved, and new responsibilities are developed.

10.37 We also identified some further learning opportunities in relation to:

- The risks associated with the potential loss of organisation memory and effective working relationships when planned changes in the oversight organisations.
- The challenges the Trust will face when the level of support from NHS England improvement team is reduced and that there is a clear plan of withdrawal with mechanisms to identify areas of increased risk which could result. All stakeholders should consider how they can strengthen the voice of the service user/carer and staff in their oversight processes.

The process for oversight of actions for all members of the system could be formalised.

Recommendation 11: Provider collaborative

<table>
<tr><td colspan="2">NHS England must review and clarify the role of the GM 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.

Within 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.</td></tr>
<tr><td>Assurance rating for this recommendation</td><td>2</td></tr>
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Key findings

11.1 We scored this recommendation as 2: We found that NHS England had made significant progress against this recommendation. GMMH was no longer the lead for the provider collaborative, with NHS England Specialised Commissioning having assumed this. NHS England had also provided support to cover vacancies in vital roles, and to ensure there was sufficient expertise and experience within the team.

11.2 The position is fragile however as there remain vacancies with the team, and many case managers are on temporary contracts (alongside the changes being made to NHS England, and described at 10.2. This means that when the contract is put out for procurement in April 2026, those on temporary contracts will not automatically be transferred to the new contract holder, posing a risk to organisational memory and experience.

11.3 Where there was less evidence of progress was the absence of a Standard Operating Procedure for information sharing and escalation of concerns. We saw records, and heard from stakeholders, that there was improved communication between them. The Trust were proactive in sharing information, (except for a warning notice from CQC in 2024). Since then, there had been changes in the Trust's leadership.

11.4 Arrangements had been put in place for NHS England Specialised Commissioning to oversee the provider collaborative until March 2026 once GMMH decided to not continue with the contract as lead provider. A procurement process will start to secure a lead provider from April 2026.

NHS England review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures. Review GMMH's position as lead provider in the provider collaborative.

11.5 We understand that the work to consider GMMH's position as the lead provider collaborative for the adult secure services in Greater Manchester commenced in Autumn 2023. No evidence was supplied to show what this work involved.

11.6 As all current contracts for NHS Lead Provider Collaboratives (LPC) were due to expire in March 2024, NHS England undertook a market engagement exercise to inform next steps. On 9 November 2023, GMMH served notice that they would not be continuing with the contract to be the lead provider collaborative when the contract expired in March 2024.

11.7 NHS England acted quickly on learning this. A paper, "Considering future options for the Greater Manchester NHS-Led Provider Collaborative for Adult Secure Mental Health Services" setting out the options was presented to NHS England's Regional Management Team in November 2023. There were two options: one was to transfer delegated responsibilities to another LPC in the North West, or to return responsibility to the specialised commissioning team. For each option there were two different dates proposed- pre-1 April 2024 or on 1 April 2024.The arrangements would last until March 2026 (to align with the review dates of the 14 other LPCs for adult secure services).

11.8 The preferred option was for the responsibility to return to Specialised Commissioning until March 2026. This was not agreed as this was not in line with the national direction of commissioning. NHS England attempted to arrange the transfer of delegation to another LPC in the North West unsuccessfully. This decision was being made in the anticipation that NHS England would be delegating the responsibilities for low and medium secure services to ICBs from April 2025.

11.9 This uncertainty in oversight arrangements was mirrored in the workforce within the LPC. The paper notes that the instability of the workforce was significant, with many in the LPC on temporary contracts. The risks of this temporary staffing were clearly identified in the paper along with how to mitigate them. We heard that NHS England had secured support in the form of providing staff for the LPC function as there were three significant gaps identified: medical lead, financial lead and quality lead. This is a temporary arrangement and needs to be considered as a risk when the contract for LPC is awarded.

11.10 This workforce has persisted until the time of writing, and it is important that steps are taken to prevent the loss of staff with knowledge, skills and experience in whichever future model is adopted.

11.11 Work is currently underway to inform a decision on successor arrangements to the LPCs across the North West. We understand that a decision was due in September 2025, although we have not seen the outcome of this.

NHS England should develop a Standard Operating Procedure within six months to provide clarity around the thresholds for information sharing and escalation of concerns

11.12 While no standard operating procedure was provided, there was evidence in the minutes supplied of open discussion between the Trust and the LPC about thresholds for escalation of incidents. There is also evidence that the Trust were actively raising issues with the LPC.

11.13 There is only evidence of two visits by the LPC to GMMH services. The minutes of contract meetings show a focus on process and inputs and would be strengthened with a view of the impact of actions taken. There were also opportunities to improve how the patient voice was heard.

11.14 The focus in the assessment of readiness for reopening wards was on nurse staffing and there was no record of consideration about risks relating to consultant cover or other key safety risks.

Residual recommendations

11.15 Reflections and learning from this process should be applied to the procurement process when contracts for lead provider collaboratives are awarded.

11.16 We also identified some further learning opportunities in relation to:

- The need for a clear plan of withdrawal when NHS England support with the LPC is withdrawn,
- The risks associated with the current temporary staff employed by the LPC not being eligible to TUPE across when the LPC contract is awarded with mechanisms to identify and mitigate areas of increased risk which could result such as loss of organisation memory.

Conclusion

12.1 This assurance review was undertaken to determine the extent to which GMMH and its partner agencies had taken appropriate action in relation to the recommendations published in our original report in January 2024. Overall, we found that there has been some positive progress made. We also found that improvements at GMMH have been somewhat impeded due to the rebuilding of a substantive and stable senior leadership team, which is now in place. However, as stated previously, this is important as the ability of the organisation to respond to the recommendations has inevitably been impacted by the need to recruit and embed a substantive executive team, which can then set a coherent direction for the organisation. It is important that, in all these leadership changes, the Trust's leaders do not forget the depth of concerns that existed within GMMH and how deeply poor care and culture had become entrenched in some parts

12.2 The foundations for the future have largely been developed, but these will require commitment and energy from all partners to ensure this early progress is embedded, to meet the needs of the people and communities that GMMH serves.

12.3 To maintain this, GMMH will need to continue to build trust with service users, and their families and carers; not all are yet persuaded that the Trust has changed, and this will require real focus to ensure changes are made. We found that work on our recommendation to ensure patients, families and carers voices had commenced but had much more to do.

12.4 There remain significant concerns about the Trust's community mental health services. We hope that the ICB will promptly complete their independent review of community mental health teams, and ensure that its findings are heard and acted upon swiftly, so that safe, reliable and responsive care is also delivered in community settings. The ICB also needs to consider if the review has met the intention of the original recommendation.

12.5 Finally, we want to thank all those who contributed to the assurance review.

Appendix 1: Glossary of terms used

Term used	Definition
AFS	Adult Forensic Services
AHP	Allied Health Professional
BAME	Black Asian Minority Ethnic Network
CEO	Chief Executive Officer
CQC	Care Quality Commission
EDI	Equality, diversity and inclusion
FTSU	Freedom to Speak Up
GMMH	Greater Manchester Mental Health NHS Foundation Trust
HR	Human Resources
ICB	Integrated Care Board
LGBTQ+	Lesbian, gay, bisexual, transgender and queer with the plus sign representing other identities not included in the acronym
LPC	Lead Provider Collaborative
MCA	Mental Capacity Act
MD	Medical Director
MDT	Multi-disciplinary team
MHA	Mental Health Act
NCISH	The National Confidential Inquiry into Suicide and Safety in Mental Health
NHS GMICB	NHS Greater Manchester Integrated Care Board
NHS England	NHS England
OIC	Observing and Improving Cultures Framework
PALS	Patient Advice and Liaison Service
PCREF	Patient Carers Race Equity Framework
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 or organisation where they believe that action should be taken to prevent further deaths.
PLACE	Patient-led assessments of the care environment
PMVA	Training in how to manage situations safely for patients and staff when patients become distressed.
PSIRF	Patient Safety Incident Response Framework
QAC	Quality Assurance Committee
SEIPS	System Engineering Initiative for Patient Safety
SIB	System Improvement Board
SLT	Senior Leadership Team
SOP	Standard Operating Procedure
VCSE	Voluntary, Community, Social Enterprise organisations

Appendix 2: Review team

This 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.

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.

Support, investigative and governance expertise was provided to the review team by Niche Health and Social Care Consulting. Niche is an employee-owned trust and a B-Corp 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. 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.