

**Manchester City Council
Report for Information**

Report to: Health Scrutiny Committee – 26 June 2024

Subject: NHS England Independent Review of Greater Manchester Mental Health NHS Foundation Trust, and service user and carer feedback

Report of: Chief Executive, Greater Manchester Mental Health NHS Foundation Trust

Summary

This paper provides details of the learning from the NHS England commissioned Independent Review of Greater Manchester Mental Health NHS Foundation Trust (GMMH) and outlines the GMMH response to the Review findings. The Review identified eleven recommendations for improvement, nine of which related to GMMH.

Service Users and Carers will be attending the meeting to share their experiences of mental health services in Manchester provided by GMMH.

Recommendations

The Health Scrutiny Committee is recommended to:

- Consider the learning and GMMH response to the findings of the NHS England commissioned Independent Review.
 - Consider the feedback from service users regarding their experience of GMMH services in Manchester.
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Wards Affected: All

Environmental Impact Assessment -the impact of the issues addressed in this report on achieving the zero-carbon target for the city.	None
Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments.	Mental illness can have a profound effect on an individual's physical and mental health and wellbeing and can have a detrimental impact on their life expectancy. Providing timely access to help and support, effective, safe, compassionate treatment and care can help reduce the health inequalities often associated with mental illness.

Manchester Strategy outcomes	Summary of how this report aligns to the Our Manchester Strategy/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	
A highly skilled city: world class and home-grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	
A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

Financial Consequences – Revenue

Not applicable.

Financial Consequences – Capital

Not applicable.

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Link to the NHS England Commissioned Independent Review:

[NHS England — North West » Independent review – Greater Manchester Mental Health NHS Foundation Trust](#)

Link to our Together Strategy

[Documents - GMMH286 GMMH Together Strategy 2023_25.pdf - All Documents \(sharepoint.com\)](#)

1.0 Introduction

- 1.1 Following the care failings identified in September 2022 by the BBC Panorama Programme, our regulators, the local Coroners, and other external reviews, we developed an Improvement Plan outlining the actions that would be taken to address the issues and concerns raised and recommendations for improvement. Our Improvement Plan was co-produced with our staff and our service users and carers and was approved by our Board in June 2023.
- 1.2 In parallel, NHS England commissioned an Independent Review of mental health services provided by GMMH. The Review was chaired by Professor Oliver Shanley and focused on three key areas:
 - Care failings within our Adult Forensic Services in the Edenfield Centre,
 - Park House,
 - The tragic deaths of three young people being cared for in our inpatient Child and Adolescent Mental Health (CAMH's) wards.
- 1.3 The findings of the Review and the eleven recommendations for improvement were contained within a report published on 31 January 2024 ([NHS England — North West » Independent review – Greater Manchester Mental Health NHS Foundation Trust](#)).
- 1.4 We shared the report widely internally and externally with our key stakeholders and we mapped the recommendations for improvement to our existing Improvement Plan.
- 1.5 This paper summarises the findings of the Review, the learning and our response to the Review findings.
- 1.6 Service users and carers will attend the meeting to share their experiences of GMMH services in Manchester.

2.0 Background

- 2.1 This Committee has previously been made aware of the care failings and stakeholder and regulator concerns regarding some of our services. This Committee has previously been briefed on our Improvement Plan and the improvement that have been made or are underway as well as some of the ongoing challenges.
- 2.2 The Committee has previously been made aware of NHS England's intention to commission an Independent Review of mental health services provided by GMMH and the publication of the Review findings on 31 January 2024.

3.0 Main issues

- 3.1 The Independent Review was very comprehensive, and the Review Team engaged with circa 400 people, including service users and carers.

3.2 The Independent Review identified eleven recommendations for improvement, (see **Figure 1**), nine of which were GMMH specific. Professor Oliver Shanley and his team presented the Independent Review findings to our Board in February 2024, following which our Board held a dedicated development session to consider the Review findings, the learning from the Review and the recommendations for improvement.

Figure1: Independent Review Recommendations



3.3 We identified lots of learning from the Review. The learning is summarised in **Figure 2**. There is also a presentation providing more detail contained within **Appendix 1**.

Figure 2: Summary of the learning from the Independent Review



3.4 One of the key learning points from the Independent Review was the importance of listening to our service users and their carers. We have been working hard to improve our listening skills and creating more opportunities for service users and carers to have a voice and to be directly involved in the work that we do and the decisions we make. Some examples include:

- Development of our Together Strategy ([Documents - GMMH286 GMMH Together Strategy 2023_25.pdf - All Documents \(sharepoint.com\)](#))
- Establishing a Service User Voice Forum
- Establishing a Patient Advisory Liaison Service (PALS)
- Strengthening patient advocacy arrangements
- Engaging services users and carers in the development of North View in North Manchester
- Engaging Service Users, carers, staff and stakeholders to develop the Clinical and Care Strategy
- Engaging Service Users and Carers in the redesign of our Community Services and the model of care in Adult Forensic Health Services
- Service users joining senior leadership team meetings within our Care Groups
- A service user sitting on our Evidence Review Panel
- Service users and carers being involved in the recruitment of our staff

3.5 For more information regarding service user and carer involvement see **Appendix 2**.

3.6 Manchester Care Group has two service user and carer forums; Our Care Matters Service User and Carer Forum and the North View Service User and Carer Forum. Some of our Manchester service users and carers will be attending the meeting to share their experiences of our Manchester services.

3.7 We shared the learning and findings of the Independent Review with our key stakeholders within and outside our organisation. Internal groups included our

Council of Governors, Senior Leaders and Care Group leaders' forums. Our Care Groups also shared the Review findings with their services and their service user and carer forums. External groups included local HealthWatch, local Health Overview Scrutiny Committees and Locality Boards.

- 3.8 Implementation of our Improvement Plan was already well underway by the time the Independent Review was published. We mapped our existing Improvement Plan to the Review recommendations for improvement and identified forty-five directly linked actions, and we found that we had already addressed a number of the recommendations for improvement contained within the report. We took this into consideration as part of formulating our response to the Review.
- 3.9 Following engagement with a broad range of key stakeholders our Board have identified eight priorities for improvement in 2024/25. These were approved at our May 2024 Board meeting and are as follows:
- We will implement and evaluate our Together Strategy to ensure that our service users, their families and carers have a strong voice and are heard at every level of the organisation.
 - We will further develop our Clinical Senate with clear points of connection with organisational and system governance to ensure that our clinicians have a strong voice within our organisation. We will develop our clinical leaders through our "Role Model, Coach, Care" leadership development programme.
 - We will co-produce to relaunch our values and create a Behavioural Framework that emphasises values of quality in care, compassion, and inclusion.
 - We will develop a People plan and recruit a workforce appropriate to the clinical environments and needs of communities. We will use our workforce information to support the safe staffing of our clinical services.
 - We will refresh our Estates Strategy objectives and priorities for 2024/25 and embed our Capital Estates and Facilities Delivery Compliance and Assurance Framework.
 - We will develop a Quality Strategy, including components of Quality Assurance, Quality Control and Quality Planning, enabled by a cross-cutting emphasis on continuous Quality Improvement.
 - We will accelerate our Adult Forensic Services Transformation Programme to define a person-centered and evidence-based clinical model and a service model for its delivery.
 - We will review our approach to learning from deaths to improve so that we improve our learning from incidents and reduce avoidable harm.
- 3.10 We are in the process of working with the leads to confirm the actions we will take and timescales for delivery. We will then refresh our Improvement Plan to reflect these improvement priorities.

4.0 Recommendations

4.1 The Committee is recommended to:

- Consider the learning and GMMH response to the findings of the NHS England commissioned Independent Review.
- Consider the feedback from service users regarding their experience of GMMH services in Manchester.

5.0 Appendices

5.1 Appendix 1: Presentation: How did we get here and what do we do next?

5.2 Appendix 2: Presentation: Service Users and Carers