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ABUSE OF POWER

Response to the Edenfield Report 2024

CHARM and GMCDP have reflected on the content and findings of the "*Independent Review into the care and treatment provided by Greater Manchester Mental Health NHS Foundation Trust"* published in January 2024.

April 2024

Summary

1. Communities for Holistic Accessible Rights-based Mental Health (CHARM) and Greater Manchester Coalition of Disabled People (GMCDP) find that there are serious omissions in both the findings and recommendations in the report: “Independent Review into the care and treatment provided by Greater Manchester Mental Health NHS Foundation Trust” (January, 2024).

2. The title of the report is grossly misleading since the report limits itself to a review of forensic services and a few inpatient services of GMMH.

3. Service users of GMMH, their relatives and carers, were not included in the review team and, hence, there was no co-production of the investigation or the report.

4. There were also no clinical or forensic psychologists on the review team. This resulted in a significant lack of psychologically-informed enquiry, knowledge and recommendations.

5. The report takes a systems-based approach rather than a rights based approach to the review. This has led to an over-emphasis on the experiences and perspectives of staff, managers and leaders of GMMH, its partner organisations and stakeholders, rather than listening to service users and their carers. The investigating team spoke to 200 staff members versus only 50 service users and carers.

6. The report fails to address the impact of the bullying and closed culture on patients and their families.

7. The highlighting of racism within the organisation is welcome but there is no specific recommendation to address the culture of racism.

8. The report’s recommendations fail to recognise the importance of co-production in the development of future services with the result that these remove power and autonomy from patients.

9. The report makes no recommendations or suggestions to review the dominant medical model of treatment and care instead of exploring alternative models that better enable the protection of patient rights and perspectives, such as the Open Dialogue approach.

10. Psychological and occupational therapies are overlooked in the report as a central component of mental health care.

11. The report makes almost no reference to the current crisis in community mental health care provided by GMMH and the direct link to the continuing crisis in in-patient and forensic services. CHARM has been warning GMMH of this since 2021.

12. The review accepts a national and local political culture of severe underfunding of services and austerity.

13. In conclusion, we must continue to call for an independent, co-produced review of how mental health services are provided in Manchester, with human rights and compassion at its centre.

1. Introduction

CHARM and GMCDP have reflected on the content and findings of the **"***Independent Review into the care and treatment provided by Greater Manchester Mental Health NHS Foundation Trust"* (published in January 2024).

Whilst we welcome the report and its insights into unsafe staffing, closed culture and failure to listen to patients and service users, we believe that there are serious omissions in the report's findings and recommendations which we have highlighted below.

We are alarmed that the report on the management of Edenfield is weak. Given the failings at Edenfield, we are shocked that the report does not recommend changing the lead provider at Edenfield from GMMH but simply asks NHS England to review it.

See our full response to the report below.

2. Concerns and Omissions

2.1 Title of the report

The report published in January 2024 led by Oliver Shanley is not an independent review about GMMH's care and treatment as suggested. More specifically it is a review of its forensic services and some inpatient services at GMMH. The title of the review therefore obfuscates some of the serious concerns regarding GMMH community teams and the wider impact of the closed culture across the Trust as a whole.

2.2 The report takes a system-based approach to the investigation rather than a rights-based approach.

There is over-emphasis on hearing the experiences and perspectives of staff and leaders of GMMH, partner organisations and stakeholders, rather than listening to service users and their carer's. For example, the investigating team spoke with 200 staff members, whilst they only spoke with 50 service users and carers in total. This will inevitably emphasise the concerns of staff and allied institutions above those of people who use services.

Specifically:

a. The report focuses on the existing system and is investigated by people in that system. As such it fails to effectively move the focus to the experiences of service users/survivors.
b. We welcome the report's acknowledgment that the Trust failed to listen to service users and carers and that the first recommendation of the report emphasises the central importance of patient family and carer voices. However, we are disappointed that this recommendation fails to recognise the importance of co-production in the development of future services. This is disappointing because the report evidences that this is what service users and carers have requested. We know that meaningful co-production means sharing power.

c. The report focuses more on statutory and mandatory perceptions of risk (such as CQC requirements on addressing ligature points, fire risks and smoking) rather than addressing concerns of service users, such as risks associated with the harmful effects of medication or the abuse of human rights.
d. We value the challenge the report makes to the current operational and managerial culture of GMMH and welcome the importance of strengthening the clinical voice. However, there is a failure to include the importance of psychology and occupational therapy within that clinical voice. There is also a failure to address and acknowledge the abuse of human rights that clinicians in positions of power have enacted.
e. In any holistic approach to change, an address to the culture of the organisation should have focused just as much on the treatment of patients and families as it did on staffing. The system-based approach has led, for example, to a recommendation that focuses' on the racist discrimination faced by staff rather than recognising that is it essential to address racism for all those in contact with the institution – staff, service users, family members and carers.

Charm is collecting Storybank of experiences available through the CHARM website in 2024 to increase understanding about the severity of the impact of human rights abuse and neglect.

2.3 The abuse of power

The report recognises that the closed managerial culture in GMMH led to senior management and governing bodies not listening to staff, including clinicians. In our view, this section of the report fails to address the impact of the bullying and closed culture on patients and their families. Consequentially, there remains a hierarchy of power, from manager to clinician to patient/carer. There is no consideration of the benefits of power sharing and co-production approaches that would directly prevent the kinds of abuses seen at Edenfield.

For example:

a. **Power sharing between clinicians and managers** would not necessarily impact on the changes to the women's blended service that was relocated to the Edenfield Centre despite the expressed wishes of the women.
   The report does not question how the blended service came into being. Changes to the women's service came into place, following an inadequate patient consultation exercise and without consideration to equality obligations. The report could have recommended more robust mechanisms for instituting change. A CHARM member spoke to 10 women at the Edenfield Centre about the changes to the women's service. None had been consulted. Only one thought the changes seemed like a good idea. A staff member gave the CHARM member a copy of GMMH's application to NHS England for changes to the women's service. At one point there is a table referring to checks made under equality rules. The box

marked "sex" seems to have been confused with "gender identity". Managers at GMMH did not appear to know the basics. Since placing all women in a more secure setting seems to discriminate on grounds of sex, there was little concern about this discrimination. If service users had been properly consulted the concerns the women had regarding the secure setting for rehabilitation could have been more adequately heard and acted on.

b. **Failure to question the model of care:**
While staffing shortages clearly exacerbated the culture at Edenfield and the services provided by GMMH, abuse and poor attitudes are not simply a question of staff shortages. There has been a refusal to consider more collaborative ways of organising services.

c. **High rate of suicides** cannot not just be addressed through the removal of ligature points, but needs to be addressed through the model of care. The report makes no recommendations or suggestions regarding reviewing the dominant model of care.

3. The abuse of human rights not adequately addressed

While the report recognises abuse that patients suffered at Edenfield:

a) this is highlighted through phrases such as ***'**patients treated in an unsafe, unkind and abusive way**'***. We find this description weak in the face of the atrocities that took place. It is more accurate to reflect that at times services were life threatening or fatal.
b) It is offensive when the report uses the passive voice for the deaths of service users e.g. '*people die unexpectedly while using their inpatient services'.*
c) While we welcome the highlighting of racism within the organisation, both in relation to discrimination faced by Black and minority ethnic staff as well as in relation to the care and attention given to service users and the recognition that black people are more than four times more likely to be detained under the MHA and people from socially deprived areas are three and a half times more likely to be detained when compared to people in affluent areas, we note that there is no specific recommendation to address the culture of racism.

4. The report continues to place emphasis on a medical model rather than exploring alternative models that better enable the protection of people's rights and perspectives, such as the Open Dialogue approach.

The report recognises the importance of a strong clinical voice, but
a) there is also a failure to investigate and acknowledge the abuse of human rights that clinicians in positions of power may have enacted.
b) Numerous junior staff have faced censure but the senior leaders and health professionals who had legal responsibility for protecting people's human rights have not faced police investigation. In failing to call this out, the report colludes with the system cover up and becomes part of the problem.

c) There were also no Clinical or Forensic Psychologists on the Review Team which resulted in a significant lack of psychologically-informed enquiry, knowledge and recommendations throughout the report.
d) Psychological therapies or interventions in the report are not seen as a central component of mental health care. For example: In paragraph **5.20**, psychologists and therapists are seen as a supplement:
"We believe there is a need for much closer, multi-professional working between the consultant and ward manager, which is ***supplemented*** *by specialist input from other members of the nursing team, psychologists and therapists".* Unfortunately, in practice, consultant psychiatrists in the Trust typically see Psychology as an optional and expensive add-on rather than a knowledge-base that should be central to the delivery of treatment and care.
e) We support the finding that assessment and care in the trust is not trauma-informed. This is exceptionally disappointing since the Trust launched its trauma-informed approach at an excellent conference a few years ago which demonstrated a wealth of knowledge and expertise within the Trust on this approach. The Trust has a complex trauma research unit at Manchester University. This learning has not transferred to the Trust's practice.
f) The Trusts's improvement plan only pays brief lip service to 'adapt a collaborative and trauma-informed approach to care' https://www.gmmh.nhs.uk/improvement-plan (p17) Currently the trust's training is a measely one day training for staff.
g) The trust's approach largely involves asking service users about their history of trauma during an initial assessment.
h) There is no trauma informed ***care***. Little is done to organise services and service users' relationship to services with trauma in mind, e.g. ensuring continuity and stability with one key worker, reliable communication etc.
i) The current model of care does not take on board new approaches to supporting people in severe distress such as e.g. Open Dialogue, the Hearing voices approach. Both these approaches would support and ensure the protection of people's human rights.

5. Listening to service user/survivor voices and family/carer voices means acting on their concerns.

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

The need for co-production is not highlighted in the report recommendations.

a) Co-production reduces inequalities of power. Power inequalities provide fertile ground from which abuse can spring. Without addressing this the current process could end up simply being another stop gap in a long story of abuses in the mental health system.
b) This report mentions service user/survivor voices a few times. But more often, the voice of the workforce, commissioners, and management are prominent.

c) Recommendation 12.3 even suggest the Trusts strapline as worthy of being 'reignite(d)'. Yet "*clinically led, managerially partnered and academically informed*" completely devalues the voice of patients/survivors, family members and carers. It provides no vision or intention to meaningfully share power with or listen to the community who use services?
d) The failure to take a co-production approach has led to recommendations that remove power and autonomy from patients, with vague phrases such as 'quality of care' that have not been defined within the report. A rights-based approach would emphasise respect for an individual's rights and values as central to any care approach.
e) The failure to listen and act on the voice of service users/survivors and carers can be seen by the failure to implement the Mental Health Charter which the trust signed up to in 2014 Charter for Mental Health Services in Manchester | Manchester Community Central
f) The gravity of concerns that exist has led to CHARM setting up a story bank to collect the experiences of those who have used services. Our podcast series will launch in early 2024 on the CHARM website.

6. The Culture of GMMH

Recommendations for changing the culture of the organisation focus entirely on the staff experience and not on service users and carers.

a. Recommendation 3 states *'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'*
b. This recommendation should at the very least argued that the culture of the organisation should ensure that ***no staff, service user or carer experience discrimination***
c. Culture change also requires an overhaul of the entire model of care. Since the 1980's, 250 billion has been spend on mental health services in England but It is the only the area of medicine where outcomes have stalled and by some measures are even going backwards. (see Dr James Davies, 2021, Sedated: How Modern Capitalism Created our Mental Health Crisis)
d. True culture change will require co-production with all stakeholders. This includes the population served. There needs to be immediate clear board level representation of service user/survivors, not simply one or two to tick a box, but a power bloc that can veto decisions emanating from system embedded factions. The practice of how power operates within Edenfield must be analysed and changed. This needs to be funded and facilitated by an external independent community /user led organisation.

e. What communities have been asking for regarding mental health services is small neighbourhood level provision, not large institutional infrastructure. Both power sharing within co-production and neighbourhood level service mitigates against abuse and can set the terrain for an actual transformation to a better system. Edenfield will never provide what is needed and maintains an approach that can always tend towards behind closed doors abuse.

f. What we ask for is not unrealistic. New community mental health pilot projects are being developed. [Community Mental Health Framework Pilot Evaluation - PenARC (nihr.ac.uk)] Manchester must be part of these approaches that through their structures can ensure human rights are better respected.

6. Financial and Performance Challenges

The report recognises but understates the performance and financial pressures on GMMH from NHS England via piggy-in-the-middle commissioners. This is a national political problem with the funding of mental health services and herein lies one of the root causes of the catastrophic failure of mental health services nationally.

a. The report rightly highlights that staff were being allocated, based on available budgets, rather than on clinical need.
b. However, Recommendation 4 accepts a political culture of underfunding and austerity. It states '*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.'* This is not acceptable.
c. The recommendation fails to address a number of wider systemic issues in Manchester, which have exacerbated the exceptionally poor levels of staffing that the report highlights. (30% less care hours per day from registered clinical staff than other NHS mental health trusts).
d. While Manchester has some of the highest need nationally in terms of mental health need (we are in the top 10% of NHS's Index of need), we are in the bottom quartile in terms of spend. The situation in the city of Manchester is particularly acute. The city of Manchester receives less spend per weighted capita than other areas of Greater Manchester. This is an issue that the Integrated Care Board and the Health Scrutiny committee need to address urgently. (CHARM submission to Manchester City Council Health Scrutiny Committee 24 May 2023, Agenda item 5, https://charmmentalhealth.org/2023/05/31/edenfield-and-the-mental-health-crisis-in-the-city-of-manchester-how-it-is-connected-and-can-we-sort-it-out/)
e. However, recommendation 10 asks these organisations to monitor themselves '*The organisations with responsibility for regulation, oversight and support to GMMH must review their current systems of quality assurance…'*
f. In the detailed recommendations, the report does not ask the ICB to review the funding allocation for mental health in Manchester, which is inadequate. The report notes **…** *margins have been significantly eroded over the last six years, which leaves less scope for investment in in-patient care. Most of the Trust's income is via a "block contract" (88% in 2021/22) which means that it receives a set amount of money, for certain services it provides, regardless of how busy these services are…'* (3.32) We believe that the ICB must address these failings urgently.

7. Failure of Community Mental Health Care services directly linked to crisis in in-patient and forensic care

We are disappointed that the report makes almost no reference to the shambolic state of community care provided by GMMH.

a) It is clear, that the evidence provided by CHARM to the Manchester Health Scrutiny Committee in 2023 re. community care service failures, the recent investigations by the CQC regarding community services, as well as concerns continually expressed by CHARM regarding the neglect of people requiring support in community, with hundreds being 'stepped down' without adequate regard to their safety are key contributors to the current crisis. (https://charmmentalhealth.files.wordpress.com/2021/04/2019.10_discharge_pathway_project_report_-_final.pdf)
b) In our view there is a strong connection between the closed culture that was uncovered at Edenfield and at senior management level and the failures in the Manchester community mental health service system.
c) CHARM warned GMMH in 2021 that there was a growing crisis in community care, GMMH denied this and sought to reassure service users and carers that services were safe and available. This has proven not to be the case.
d) The recent report by NHS England has revealed the extent of neglect in community mental health teams that has led to the deaths of at least 15,000 people between 2022-2023. One trust had 500 deaths. These deaths do not include Early Intervention, Perinatal services or crisis services, meaning that this report does not reveal the total level of crisis. This further evidences that you cannot look at inpatient services without looking at community mental health teams.
e) There are now long waiting list in Manchester for being assigned a community care coordinator, in-spite of being assessed as requiring support. Further, high case loads, shortage of staff and growing levels of demand has led to issues of safety and neglect that are at least as significant as those discovered at Edenfield.
f) The stresses on the whole system are now massive, from the point of first access to secondary services via Crisis Helplines; Accident and Emergency; Police interventions; Primary Care referrals and the long waiting lists for assessment for conditions such as ADHD and Autism and lack of services to meet their needs. Further, discharge and step-down procedures are placing vulnerable people at risk.

7.1 GMMH Crisis Help lines and Support:

"… people using the service and their carers also told us they struggled to contact the service for support or when in crisis. This left people at risk of harm as they had no way to tell staff their mental health had worsened." *Brian Cranna, CQC's head of hospital inspection, June 2022*

7.2 Emergency Departments:

a) “A ‘disappointingly slow’ transformation of community services means thousands of mental health patients are still presenting at emergency departments within weeks of being discharged from an inpatient facility.” *Health Service Journal, June 2023*
b) “Evidence the confederation has collected from NHS trusts in England shows that some mental health patients are in such poor health that they have to be admitted to acute hospitals because there are no beds free in specialist psychiatric facilities for them or other help available. People are coming to A&E and having to wait very long periods of time either to be admitted or found the right package of care for those needs in the community. NHS leaders say that this is now leading to thousands of patients being admitted to acute care beds when this may not be the right clinical setting for them and risks their mental health deteriorating further as a result”. *NHS Confederation, October 2023*
c) CHARM members and supporters have experienced this lack of support leading to emergency admissions for some years now.

7.3 The role of Police:

a) Police in England and Wales dealing with more mental health crises than ever with Forces saying increase highlights erosion of mental health services in recent years. Further freedom of information requests made by the Labour Party revealed that some forces across England and Wales experienced a tripling in mental health requests between 2019 and 2021, data shows*. Labour Party, February 2023* (see CHARM Health Scrutiny Cttee Report p3 regarding Manchester)
b) Police forces across England will, in future, stop attending mental health-related incidents unless there is a significant risk to safety or a crime being committed, and refer cases to health or social care services instead. *NHS England, July 2023*

7.4 Primary Care and Discharge and step-down procedures:

The Manchester Mental Health Charter Alliance has struggled for years to hold the trust and the commissioners to account over the shambles of stepping down in Manchester.

a) After years of silence and failure by GMMH to address the criticisms contained in the Mind Discharge Pathway Project Report and the apparent little interest from other public bodies to force them to do so, despite the evidence from Service users/survivors, they made a complaint to the Commissioners about the lack of action. (Charter Alliance July 2021)

7.5 Long waiting lists for assessment and receipt of service

In GMMH in May, 2023 there are were 1545 of the most vulnerable people who have been assessed as needing a care coordinator placed on a waiting list. 1,167 of these people are in the city of Manchester.

a) Community Mental Health Teams in the city of Manchester are struggling with unmanageable case loads.

b) The disproportionate number of people waiting for care coordinators in the city of Manchester compared to Greater Manchester can only be described as a dereliction of duty by GMMH to the City of Manchester.

Division	Full Team Name	Number of Open Cases	Number of Unallocated Cases
Bolton	BOL - NORTH FUNCTIONAL TEAM	841	90 (total Bolton)
Bolton	BOL - SOUTH FUNCTIONAL TEAM	767	-
Manchester Central and South	MCR - CMHT CENTRAL EAST	1527	296
Manchester Central and South	MCR - CMHT CENTRAL WEST	1130	127
Manchester Central and South	MCR - CMHT MERSEY NORTH	717	42
Manchester Central and South	MCR - CMHT MERSEY SOUTH	772	49
Manchester North	MCR - CMHT NORTH EAST	1534	317
Manchester North	MCR - CMHT NORTH WEST	1381	336
Salford	SAL - CROMWELL HOUSE CMHT	1231	146 (total Salford)
Salford	SAL - PRESCOTT HOUSE CMHT	815	-
Salford	SAL - RAMSGATE HOUSE CMHT	1067	-
Trafford	TF - CENTRAL TEAM	207	142 (total Trafford)
Trafford	TF - NORTH TEAM	252	-
Trafford	TF - SOUTH TEAM	310	-
Trafford	TF - WEST TEAM	291	-
Wigan	WIG - RECOVERY TEAM NORTH	893	0
Wigan	WIG - RECOVERY TEAM SOUTH	647	0

c) In failures start in Primary Care:

d) the waiting lists for assessments for conditions such as ADHD and Autism are particularly acute. Without such assessments people find it hard to access support. ADHD services 'are receiving a very high number of referrals which far exceed the number of people we are able to support, John Foley, Chief Operating Officer at Greater Manchester Mental Health NHS Foundation Trust. *Greater Manchester Mental Health Trust, April 2024*

e) Ananlysis shows that in **Greater Manchester** some patients were having to wait more than 90 days between their first and second appointments in the first half of 2022. In addition, some health bodies in the city-region are failing to meet the target that 75% of people who gets referred for IAPT has their first appointment with a therapist within six weeks. *Manchester World, October 2022*

f) The impact accumulates and leads to unrecognised increasing needs, late admissions and detentions under the Mental Health Act and most importantly a lack of personalised support to the many people who rely on secondary services in the community.

Conclusion:

We continue to call for an independent, co-produced review of how mental health services are provided in Manchester with human rights and compassion at its centre.