

HMP & YOI Styal

Inspection report

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to 10 May 2024 (remote)
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Inspected but not rated



Are services safe?

Inspected but not rated



Are services effective?

Inspected but not rated



Are services caring?

Inspected but not rated



Are services responsive to people's needs?

Inspected but not rated



Are services well-led?

Inspected but not rated



Overall summary

We carried out an unannounced comprehensive inspection of healthcare services provided by Spectrum Community Health C.I.C. (Spectrum) at HMP & YOI Styal. We visited the services between 30 April and 2 May 2024, and continued to inspect remotely until 10 May 2024.

The purpose of this comprehensive inspection was to determine if the health care services provided by Spectrum were meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that patients were receiving safe care and treatment.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection, we found:

- Medicines management was not safe and effective enough with the issues we found ranging from the availability of medicines, poor record-keeping, delays to administration, and medicines errors due to insufficient storage space.
- Infection prevention and control was inadequate with poor standards of cleanliness in clinical environments.
- The health care service lacked stable and consistent leadership, which had a significant impact on primary healthcare.
- There was insufficient or ineffective scrutiny and oversight of the safety and quality of the service.
- Primary healthcare lacked sufficient numbers of suitably qualified and experienced staff to provide a safe service.
- Primary healthcare staff did not receive the appropriate training and supervision to support them in their roles.
- Primary healthcare staff worked under pressure in challenging circumstances and worried about keeping patients safe.
- Patients did not always receive their planned social care support in a timely manner, especially in the evening and during the night.

However, we also found:

- Staff showed a strong commitment to their colleagues and patients and worked hard to provide a full service in challenging circumstances.
- Staff completed timely assessments of patients' needs and risks and planned appropriate care and treatment.
- Staff from other teams saw the pressure that primary healthcare was under and offered to help whenever they could.
- The integrated substance misuse service provided a safe and responsive service in line with the relevant clinical guidelines.
- The service had an experienced and dedicated social care lead who oversaw all social care matters and ensured patients received the personal care, aids and adaptations they needed in a timely manner.

Overall summary

We found breaches in relation to Regulation 12 Safe care and treatment, Regulation 17 Good governance, and Regulation 18 Staffing. We took enforcement action, and we will keep the service under review.

The provider **must**:

- Ensure that critical and emergency medicines are available and managed in line with the provider's procedures.
- Ensure patients receive critical medicines at the times they are prescribed.
- Ensure prescription stationery is managed securely.
- Ensure the correct monitoring of ambient temperatures and act where needed to ensure that medicines remain suitable for use.
- Ensure there is always legal authorisation to administer medicines.
- Ensure audits related to medicines management are taking place, including the monitoring of omitted doses.
- Ensure sufficient numbers of suitably qualified and experienced staff to provide a safe service.
- Ensure sufficient staffing capacity especially during late and night shifts to meet patients' social care needs in a timely manner.
- Maintain adequate infection prevention and control standards.
- Ensure emergency equipment is available, in date, and regularly checked.
- Ensure that governance systems and processes are fit for purpose and utilised appropriately to effectively monitor the safety and quality of services.

In addition to the breaches, the provider **should**:

- Ensure the robust management of 'in possession' (IP) medicines and that records are completed in a timely manner.
- Ensure 'medicines in possession risk assessments' (MIPRAs) are completed and accurately reflect the status of the patient.
- Ensure all staff can access current copies of Patient Group Directions (PGDs) when they are administering medicines.
- Ensure patients comply with the requirements attached to their IP status, for example, secure storage.
- Improve the storage of medicines at medicines administration points (MAPs) so that it is clear if they are available for administration.
- Cleanse data and keep records such as waiting lists, tasks and reviews updated.

Overall summary

- Improve the quality of care records and record-keeping practices.
- Submit statutory notifications to CQC and other agencies where required.
- Ensure that patients' complaints are handled in a timely manner.

Our inspection team

Our inspection team was made up of 3 Health and Justice inspectors and a pharmacist specialist.

How we carried out this inspection

Before the inspection, we reviewed a range of information and data that we held about the service and information sent to us by the commissioner.

During the on-site inspection, we looked at the quality of the healthcare environment and facilities, and at systems and processes relating to the running of the service. We reviewed medicines management practices and looked at patients' care and treatment records. We spoke with a range of staff in healthcare including the interim head of healthcare and other senior managers, nurses, pharmacy staff, GPs, healthcare assistants, administrative staff and specialist practitioners.

During the remote part of our inspection, we spoke with healthcare staff and key partners, including commissioners. We collated further information about the service, reviewed care records and analysed performance data.

Background to HMP & YOI Styal

HMP & YOI Styal is operated by HM Prison Service. It is a women's prison located in Cheshire and holds up to 450 women. It is a busy prison with a high turnover of prisoners and a short average length of stay. The prison population includes those on remand, sentenced prisoners, recalled prisoners, and pregnant women. The prison experiences regular transfers in and out.

Most prisoners live in house blocks. The site also has a vulnerable adults unit and a wing (Waite) that holds the Care and Separation Unit. Health care services are based in the healthcare building and a nearby portacabin.

NHS England Health has commissioned Spectrum Community Health C.I.C. (Spectrum) to provide primary healthcare, substance misuse services and social care. These services have interdependencies with other health care services provided at the prison by other providers including mental health care, perinatal care and dentistry. This inspection looked at the services provided by Spectrum.

Spectrum is registered with CQC to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder, or injury and family planning services.

Are services safe?

Safe and clean environment

- The healthcare building accommodated primary care services, pharmacy, recovery services and medicines administration points. The busy pharmacy was located in a small room and had insufficient storage. Staff worked in cramped conditions and did not always have access to a sink. Work was due to start on the building of a new healthcare unit in August 2024, with a completion date of early 2025, which would offer a new pharmacy and improved facilities. In the meantime, the provider was exploring the possibility of procuring an interim pharmacy unit.
- Healthcare services did not always operate in a safe and clean environment. Many of the treatment rooms we inspected were cluttered, dirty and worn with damaged surfaces leading to potential infection risks. The prison was responsible for the maintenance and repair of the buildings and provided a cleaning contractor for general cleaning within healthcare. Healthcare staff were responsible for maintaining clinical standards of hygiene, which we found were not always adequate. For example, we observed dead insects on window sills and lights, a Methasoft machine that had not been cleaned and overfilled sharps bins.
- The clinic room on Waite wing had no hot water. Healthcare managers did not know about this and no staff had reported this issue. We were unable to determine how long the room had been without hot water. This presented an infection control risk as staff were unable to follow effective hand hygiene procedures before administering medicines.
- In the Waite wing clinic room, we found overfilled sharps bins and multiple bins waiting to be removed for incineration. In the Care and Separation Unit (CSU), the bin was overfilled to the brim with sharps, gloves, and various medicines when it should only be used for sharps and not filled with other contaminants. Also on the CSU, we found an unwashed methadone beaker with approximately 3ml of unused methadone in the bottom. The bag in Waite wing clinic room had contaminated fresh dressings with old blood.
- Emergency resuscitation equipment was placed at key points in the prison and checked regularly. However, we found out of date stock in 3 of the 4 dressings bags that included tissue glues, steri-strip paper sutures, reagent strips and nebuliser pods.

Safe staffing

- The service did not have sufficient staff to meet the needs of its patients. The skill mix and experience of staff was too limited to fully meet patients' complex care needs. The service had experienced ongoing recruitment and retention difficulties and relied heavily on temporary staff. These issues presented significant challenges to the provider when planning and delivering care and treatment to patients.
- Commissioners and the provider were aware of these issues and gaps, which had increased since the contract was renewed in April 2023. The provider and commissioners had been in discussions about the service model and staffing levels for some time. In the interim, the provider had estimated and funded the level of staffing they needed to maintain a safe service. They had also submitted a business case setting out their proposed new workforce model and the additional funding required. However, commissioners had placed this on hold pending the outcome of an independent review of the provider's proposed workforce model. At the time of our inspection, no decisions had been made.
- The primary health care team had several vacancies for nurses and healthcare assistants. The provider relied heavily on bank and agency staff to help fill shifts but could not always ensure minimum staffing levels for all shifts. We

Are services safe?

reviewed staff rotas from December 2023 to April 2024 and found there were periods where staffing levels were low or unsafe based on the provider's minimum safe staffing levels of 6 staff on the morning shift, 6 staff on the afternoon shift and 2 staff at night. Staffing levels ranged from 2 to 4 for day time shifts. The rotas showed whole weeks where only 1 member of staff was on the shift at night.

- Some staff with specific skill sets were not always utilised effectively, such as paramedics. One clinician told us they took blood samples for their own patients because of the limited number of nurses trained to do so (and also because it saved time).
- Other teams also commented on staffing pressures in the primary care service and the impact this had on activities such as health screening for late arrivals, overnight observations and personal care needs.
- The provider had an integrated substance misuse service made up of clinical and recovery teams. The clinical team was made up of nurses, an assistant practitioner, healthcare assistants and a non-medical prescriber. The recovery team was comprised of practitioners and support workers, and at the time of our inspection, had 1 vacancy for a support worker post.
- The service benefited from being a specialist 'ring-fenced' team, which helped staff ensure their patients received timely and appropriate care. Staff helped primary healthcare when they had the spare time to do so, for example, with medicines administration and personal care tasks.
- The service was able to provide a comprehensive range of interventions based on patients' needs. However, the recovery service had reduced compared to previous years. For example, the recovery team had no intervention worker or administrative support. Some roles appeared stretched, for example, the team leader managed staff, held a caseload and was involved in development work. The service had submitted a business case to the provider for additional resources.
- The clinical team did not have dedicated nursing cover at weekends, but instead relied on primary care nursing provision. The team perceived this to be a gap and had submitted a business case for an additional dedicated nursing post.
- The service had a dedicated social care coordinator who provided most of the personal care that patients needed. The coordinator was available from 8.30am to 3.45pm, Monday to Friday. Out of these hours, social care needs were covered by the primary health care staff who were on duty in the afternoon (for example healthcare assistants) and at night (nurses).
- The level of social care need varied due to continuous population changes, which meant the level of demand on primary health care staff was also variable. At the time of our inspection, the service supported 8 patients with social care needs. We found that staffing pressures across primary healthcare affected the timely provision of care to patients with social care needs, especially during the night, when there were 2 nurses on duty and no healthcare assistants.

Assessing and managing risk to patients and staff

- Primary care staff ensured that new prisoners promptly received an initial health screening at reception. They identified any immediate needs and risks and made onward referrals to other health specialities, where appropriate.

Are services safe?

- Patients received timely assessment of their physical health, maternal needs, mental health, substance misuse or social care needs. The service worked closely with other healthcare professionals such as the midwife to assess and manage patients' risks.
- The service offered a range of clinics, which had reasonable waiting lists. The service had a daily emergency response clinician who attended to urgent concerns throughout the day, such as self-harm, or other medical needs.
- A specialist nurse monitored and managed patients with long-term conditions such as asthma and diabetes. There were 25 patients on the waiting list for reviews waiting no longer than 5 weeks.
- The provider held a range of effective meetings to discuss patients' needs and risks and share information. These included daily safety huddles and weekly multi-disciplinary meetings. During our inspection, we observed a safety huddle and a multi-disciplinary meeting. They had good attendance and contributions from staff and generated useful discussions. Staff raised concerns about patients as well as other issues. There was a strong focus on patients' risks and needs.
- The provider had a good understanding of the level of risk associated with patients receiving treatment for detoxification. This meant that the substance misuse team was essentially 'ring-fenced' and could assess and manage risks effectively. Staff always had access to a prescriber and could obtain urgent prescriptions for their patients without delay.
- Staff identified any patient with drug or alcohol dependency and ensured they received the appropriate care and treatment in a timely manner. For example, patients received close monitoring in the early days of their treatment, according to their needs and risks, in line with clinical guidelines.
- Staff sometimes experienced challenges when trying to complete checks and observations. For example, they were often delayed in seeing patients in the mornings due to lengthy medicines administration rounds. They could not always get access to patients during prison lockdowns and emergencies having to observe them through the cell door. The team relied on the primary care nurses on night shifts to complete regular observations throughout the night but knew there was not always enough capacity to do so.
- A dedicated social care coordinator promptly assessed any patients with social care needs and made timely referrals to the local authority's adult social care team. Staff, with agreement from the local authority, ensured that patients' needs were met while they were waiting for a formal social care assessment. This arrangement helped mitigate any risks associated with delays.

Staff access to essential information

- The service used a secure system for recording and managing all patients' care records (SystemOne). The social care coordinator also maintained a separate social care file for each patient, which held copies of referrals, assessments and care plans.
- We sampled some care records and found they were not always complete, accurate or up to date. We found gaps, for example, some did not contain the appropriate assessments, care plans or reviews. We found the quality of notes ranged from excellent to limited, for example, we found only brief notes for some patients with significant health concerns, with little or no history, diagnosis, or plan of care.

Are services safe?

- The service used SystemOne for scheduling clinics and appointments and maintaining waiting lists. We reviewed waiting lists and found they were not always up to date, reliable or accurate. We found duplicate tasks, overdue reviews, and names not removed after appointments had been offered. The provider had recognised this was an issue and had plans to cleanse the data in the near future.
- The electronic system could only be accessed by authorised staff. Staff ensured they locked the records when they left their work stations. Staff were aware of the need to maintain patient confidentiality when discussing patients with prison staff.

Medicines management

- Medicines management was poor overall. The provider was aware of many of the issues associated with pharmacy and medicines management and had developed a medicines improvement plan.
- The provider had the responsibility for pharmacy and medicines management for all patients across the whole health care service. Medicines were dispensed from the onsite pharmacy and administered from medicines administration points (MAPs). MAPs were cramped with limited storage and staff did not always have access to a sink. Administration occurred up to 3 times a day. The morning session often took up to 3 hours. Staff told us that they could spend up to 10 hours a day on medicines administration.
- Monitoring of clinic room temperatures to ensure the safe storage of medicines was poor and there was no clear process for escalating concerns. We found that the Waite wing clinic room had a thermometer but no room temperature log. The temperature was 28.5C but the air conditioning unit was not turned on. Air conditioning was not available in all medicines administration points (MAPs).
- There were frequent transfers of patients' medicines from between cupboards in MAPs and between MAPs. Staff told us that patient-specific medicines were not always available and so they had to use medicines from their supply stock, or those kept in the emergency cupboard, which was not appropriate. Sometimes, staff used other patients' medicines.
- During our visit to the Waite wing clinic room, the stock medicines cabinet was unlocked with its doors open and held such medicines as diazepam and co-codamol. However, the room was locked and not accessible to prisoners or officers.
- Patients did not always receive their medicines in line with their prescriptions. One patient had insulin prescribed 3 times a day with meals but only received it twice a day. Patients prescribed long-acting injections (depots) for psychiatric illness did not always receive them on the day they were due.
- The service used an electronic care records system (SystemOne) to manage medicines. We found that records were not accurate or reliable. For example, we found blank boxes where medicines should have been administered. In the past 3 months, the records showed 554 omitted doses with 253 of these stating that the medicine was unavailable. The service did not audit omitted doses, which meant they did not have a complete picture of the issue. We also saw a blank box for a critical medicine (lithium) that had not been reported as an incident although on other occasions when patients had refused their critical medicines, they had been escalated appropriately. One patient did not have insulin prescribed on her record even though staff were administering it to her from a supply brought into the prison.

Are services safe?

- The service did not always manage controlled drugs (CDs) and CD records in line with the relevant national guidance and legislation. For example, in the CSU, we found the CD cabinet had an unwashed methadone beaker with approximately 3ml of unused methadone in the bottom. We checked the CD register and found that staff had not reconciled the methadone since 2 April 2024 even though they had dispensed it since.
- We found that the 'in possession' (IP) process was not always safe and effective. At the time of our inspection, 47% of patients managed their own medicines. Patients collected their medicines at a designated clinic on Friday afternoons, which was operating at maximum capacity. Patients had secure lockers in their house blocks to store their medicines. However, we were not assured that patients were complying with the requirements attached to their IP status as during a visit to one of the houses, we found that a patient was keeping her medicines unsecured in her shared bedroom.
- We found that records relating to IP decisions were not always complete or accurate. There was a backlog for completion of in possession risk assessments (MIPRAs). We found inconsistencies, for example, 2 assessments stated that the patients were not in possession (NIP) yet the patients were self-administering medicines such as insulin, antipsychotic and antidepressants.
- It was difficult to tell whether IP medicines had been collected by the patients as administration charts were not always completed or accurate. One patient had her steroid inhaler prescribed for increasing breathlessness a fortnight earlier, but had still not received it during our inspection, at which time she had a clinic appointment for a 2-week review.
- We reviewed the provider's IP policy and found it did not include guidance on how staff should record the issuing of IP medicines to patients. The policy also included references to Nursing and Midwifery Council (NMC) guidance that had been withdrawn in 2019.
- The service had an emergency drugs cupboard that held medicines for use out of hours, which staff could access, when needed. The service had a critical medicines standard operating procedure (SOP) in place, and an SOP for issuing medicines from the emergency cupboard but this had not been signed by staff.
- We found that staff were not completing the log to record items taken from the emergency cupboard in line with the provider's policies. We also found that emergency stock was not always available when needed. For example, during the weekend before our inspection, there had been no insulin available even though it was a critical medicine. This led to a delay for a newly arrived patient who needed insulin, resulting in hospital admission. The provider had since ensured that insulin was available out of hours. During our inspection, we found that salbutamol inhalers were not available for emergency use.
- We found that the management of prescription stationery was not secure and there were no checks in place to monitor usage. The FP10 prescriptions were not stored in the controlled drugs cupboard in line with provider's policy, they were stored in the emergency medicines cupboard. The current record system could not account for 10 prescriptions missing from the cupboard. There were no checks on the secure handling of stationery.
- The service had met medicines reconciliation targets with 100% achieved in March 2024. However, staff routinely used the Summary Care Record only, which was not in line with recommended practice, which advises cross checking against different sources of information. A clinical pharmacist completed medicine optimisation reviews remotely.

Are services safe?

- Patient Group Directive (PGD) documents were not readily available to staff when supplying or administering medicines under PGDs.
- The service had a clear process for managing medicines for patients being transferred or released. Data showed that around 76% of patients were transferred with their medicines but only 13% were released with their medicines. However, the provider explained that this may not be accurate having identified some data capture issues.
- Systems and processes for patients requiring opiate substitution treatment (OST) worked well. Primary care and substance misuse staff promptly identified patients' needs and arranged for the appropriate medicines. The assistant practitioner collated a list of all medicines required the following week and gave it to the pharmacy to ensure availability.
- Staff had good and easy access to prescribers. Staff told us, "There is always a prescriber on duty." The provider had out of hours prescribing cover including 'on-call' although staff described the arrangements for Sundays as "fragile." Occasionally, staff experienced difficulties obtaining methadone prescriptions from community pharmacies for patients in prison for a short time and already in treatment. However, staff found solutions and work arounds when needed.
- OST was administered by primary care staff during their morning medicines administration rounds in the healthcare building and on Waite wing. The service had 10 patients in receipt of Buvidal (a long-acting OST injection) who attended separate clinics for their medicines.
- The pharmacy held a stock of medicines typically used to treat symptoms of drug and alcohol withdrawal, for example, librium, methadone and diazepam. This helped ensure that suitable treatment was available for patients.

Track record on safety

- We found that delays in care and treatment had led to patient harm or had placed patients at high risk of avoidable harm. For example, a patient had informed reception staff on arrival that she required insulin, but it was not available. Her blood sugar levels were not taken for over 5 hours even though the care notes indicated the need to do so every 2 to 4 hours. The patient was admitted to hospital suffering from diabetic keto acidosis (a serious complication of diabetes that can be life-threatening). On return to the prison, staff were unable to check the patient's blood sugar levels as there was no equipment available.
- In another case, a patient presented to healthcare with left-sided weakness and numbness. The clinician's notes were brief and did not show an appropriate history, assessment, diagnosis, or care plan. The patient presented 4 more times over 2 weeks with worsening symptoms including slurred speech before she was taken by ambulance to hospital. At the time of our inspection, her final diagnosis remained unclear, however, her presenting signs and symptoms indicated the need for more robust intervention and monitoring.
- A mental health patient prescribed a weekly depot injection due to the unstable nature of her illness did not always receive it on time. At the time of our inspection, the delays each week had added up to a total delay of a full 7 days overall. Records showed the depot had been missed on one occasion. On another occasion, staff could not confirm if a depot had been given. The patient had been moved to segregation due to a decline in her mental health and associated behaviours. A clinical opinion from the mental health team indicated there was a strong possibility that the irregularity (and possible omission) of treatment had contributed to the patient's decline.

Are services safe?

Reporting incidents and learning from when things go wrong

- The provider had adopted the new Patient Safety Incident Response Framework (PSIRF) and had modified its systems and processes for managing incidents accordingly.
- Staff knew how to report incidents on the provider's incident reporting system (Datix). However, during our inspection, we found inconsistencies in reporting, which made it difficult to establish an accurate picture of the scale and severity of incidents at the service. We found examples of incidents reported on behalf of staff who were not able to access the Datix system themselves. During our inspection, we found incidents that had not been reported. Staff told us they did not always complete an incident report when medicines were missing (although pharmacy staff logged any requests for additional medicines). We found that the harm levels attributed to incidents was not always correct, for example, missed critical medicines noted as 'no harm'.
- We reviewed incident data. On average, around 20 to 25 incidents were reported each month. For the period July 2023 and April 2024, the 3 most common incidents reported related to staffing issues (28), medicines administration (25), and stock and storage of medicines (22).
- We found that the provider did not always submit statutory notifications to Care Quality Commission (CQC) when it would have been appropriate to do so. We found several examples of incidents that resulted in harm or had a likelihood of harm that were not reported. We found reports of unsafe staffing levels and serious medicines errors or omissions that potentially amounted to 'neglect and acts of omission which cause harm or place [patients] at risk of harm', and therefore should have been notified to CQC.
- Incident management included oversight and input from local and senior managers. Local managers completed initial investigations. Senior managers determined if early case reviews and after-action reviews were required for specific incidents. Managers identified lessons learned and took remedial action or made improvements as appropriate. However, the staff we spoke with could not recall receiving any feedback on the incidents they had reported, including any lessons learned.
- Incidents were discussed at regular medicines management meetings and integrated governance team meetings. Managers also discussed the outcomes of external clinical reviews and death in custody investigations.

Are services effective?

Assessment of needs and planning of care

- Patients received comprehensive assessments of their needs. Staff completed initial health screenings on reception with newly arrived prisoners followed by secondary screening assessments to identify any additional needs and plan appropriate care and treatment.
- Patients had care plans that showed their needs and the care and treatment they required. However, staffing pressures meant that care plans were not always personalised and up to date.
- Primary care staff made referrals to specialists and secondary care where needed and managed all external appointments. Specialist services such as mental health, substance misuse, social care and midwifery completed further assessments and planned care and treatment for their patients.
- The substance misuse clinical and recovery teams worked together to provide a coordinated care pathway. The recovery team checked for new referrals every day and informed clinical staff of those patients in need of prescribed treatment and close observation for their dependency. Clinical staff completed routine health checks, blood and drug tests and placed their patients on the treatment programme they needed. They planned the critical clinical observations required in the first few days of a detoxification regime and completed the day time checks but relied on primary care staff to complete the checks at night.
- The recovery team arranged to meet all patients within 3 days of their arrival to discuss suitable psychosocial interventions.
- The social care coordinator completed initial assessments of patients' social care needs, drafted brief care plans, and provided care while waiting for the local authority's formal social care assessment and care plan. However, the dedicated social care service was only available during the day, which meant that at other times, social care was not always provided in a timely manner. Already stretched primary care staff provided social care in the evenings and during the night.
- The social care coordinator and the local authority's social workers worked together effectively to ensure patients' needs were fully assessed and met. Good communication and a flexible approach ensured that patients' changing needs and any requests for reassessments were responded to without delay.

Best practice in treatment and care

- Staff provided a range of treatment and care for patients based on national guidance and best practice. However, staff vacancies and pressures in the prison meant the provider had to prioritise key functions.
- The primary care service offered a range of health checks including age-related screening programmes such as cancer screens, retinal screening and diabetic foot checks. Pregnancy testing was offered on arrival in reception.
- All women were offered sexual health screening and blood borne virus testing. Cervical screening was available, and staff encouraged women to attend. Women who required a further assessment of their sexual health were referred to local hospital services for investigation and treatment.
- Staff used the nationally recognised tools for their specialisms to assess needs and risk, plan care, monitor health, and complete observations. For example, primary care used the National Early Warning Scores (NEWS2).

Are services effective?

- The substance misuse team supported patients in line with the relevant clinical guidelines for the treatment and management of substance use. Patients received a holistic treatment programme made up of clinical treatment and psychosocial recovery interventions.
- Staff used tools such as the Clinical Institute Withdrawal Assessment (CIWA) and Clinical Opiate Withdrawal Scale (COWS) to assess patients' needs and risks and plan the appropriate checks and observations.
- At the time of our inspection, the substance misuse team supported 125 patients receiving opioid substitution treatment (OST) and 2 patients on an alcohol detoxification programme. The service offered patients a choice of treatments subject to clinical assessment. Most patients on OST received methadone (112) but 2 patients received buprenorphine-based tablets. Ten patients received prolonged release buprenorphine injections, with a further 3 patients due to start this in the coming weeks.
- Recovery team staff shared a caseload of 210 people in total. The service provided a wide range of groups, 1-1 interventions and resources that supported people's treatment and recovery. These included recovery gym, breaking free online, SMART recovery, relapse prevention, and ad hoc sessions with guest speakers and people with lived experience. Patients had access to mutual aid groups with Alcohol Anonymous (AA) visiting once a week, and Cocaine Anonymous (CA) and Narcotics Anonymous (NA) due to start groups as soon as they had prison clearance.

Skilled staff to deliver care

- The primary care service had a range of qualified and experienced staff to support effective treatment and care. The staff group included GPs, pharmacists, paramedics, nurses and healthcare support workers. However, this was not sufficient to meet the needs of the population, and staff were not always effectively utilised in their roles, for example, paramedics.
- The provider had an induction and training programme for new staff. Staff gave mixed views about this. Not all new staff had the opportunity to complete induction and training due to pressures in the services. The staff we spoke with consistently told us that new staff did not get a suitable induction, were "thrown in at the deep end", were not supported enough and therefore left quickly. Nursing staff confirmed they were unable to support and supervise staff as they needed to prioritise clinical activities.
- Overall, staff mandatory training levels were generally good but the completion rate for adult life support training was low. The provider's data showed that 16 out of 24 staff (67%) had completed Basic Life Support training and 8 out of 12 staff (67%) had completed Immediate Life Support training.
- The provider's training programme required periodic refreshers of some training courses. However, staff did not always have the time to do them. Staff told us they rarely had time for training and were expected to fit this in during their breaks or days off.
- Some specialist areas relied heavily on single staff members, who were skilled and experienced in that field, for example, long-term conditions and social care. Social care was overseen by an experienced social care coordinator who worked closely with the local authority's social workers and occupational therapists.
- The provider had a supervision policy covering managerial and clinical supervision. However, staff had not received appropriate and good quality clinical supervision over the past 12 months.

Are services effective?

- Staff received regular appraisals. The provider's data showed that 87% of primary care staff had received their annual appraisal.
- The clinical substance misuse service had suitably qualified and experienced nurses and assistant practitioners. They had good access to prescribers that included several nurse prescribers, a clinical pharmacist, GPs, and on call staff. The recovery team had a team of skilled and experienced recovery practitioners and healthcare assistants supported by a team leader.
- All staff in the substance misuse service received regular supervision, annual appraisals and had access to team meetings. Clinical staff had access to a clinical substance misuse network, online contact with other clinical substance misuse staff, and a psychiatrist with a special interest in substance use. However, the recovery team had very little access to external networks and support for their specialism due to being a stand-alone service of the provider.

Multidisciplinary and interagency teamwork

- Healthcare relied on the support of the prison to operate their service and had good working relationships with the prison governor and health link governor. They met regularly to discuss the challenges they faced in trying to provide an effective service. These included the layout of the prison environment, the facilities available, the impact of staffing pressures in healthcare and on the prison side, clinic scheduling, and the prison regime. They worked collaboratively to identify solutions, for example, the prison provided secure facilities for medicines storage in house blocks to support an increase in self-administration of prescribed medicines.
- Primary healthcare had interdependencies with many other services such as mental health, substance misuse, midwifery, social care, and dentistry. The service maintained good links and communication with local hospitals in order to manage external referrals and appointments effectively.
- While services were coordinated well and had shared pathways, the pressures in primary healthcare sometimes affected the delivery of care and treatment, for example, delays to the administration of psychiatric medicines (specifically, long-acting injections). The lengthy medicines administration rounds sometimes caused delays to other clinical activities such as observations of patients undergoing detoxification.
- The service had a range of effective multi-disciplinary meetings, for example, daily safety huddles and weekly complex cases meetings. These were well attended with contributions from all specialisms. Staff shared concerns about patients, sought advice and identified solutions.
- The clinical and recovery substance misuse teams met together weekly as an integrated team as well as holding separate meetings for their specialisms. The team worked closely with prison staff. Staff supported the offender management team with release planning. The team regularly liaised with the drug strategy governor and attended a number of different prison-led meetings such as drug strategy, safety intervention, and security meetings. They shared information about the current risks and trends in relation to illicit substances, updates on tradeable medicines, and any security concerns relating to drugs.
- There was a draft joint memorandum of understanding (MOU) between the prison, the provider and the local authority that covered the arrangements for social care. The social care coordinator had good working relationships with the local authority's social workers and occupational therapists and met them monthly to discuss patients who were in receipt of care packages.

Are services effective?

Good practice in applying the Mental Capacity Act

- Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and the principles that underpinned it.
- Staff understood the need to seek consent from patients when providing healthcare. Staff supported patients to make their own decisions.
- Staff discussed any concerns they had about a patient's capacity and noted them in patients' care records.
- The service had good links with the local authority and were aware they could raise any concerns about people's capacity for further assessment and intervention.

Are services caring?

Kindness, privacy, dignity, respect, compassion and support

- Staff knew their patients well and treated them in a dignified and respectful manner. They endeavoured to provide a good service to patients despite the pressure they were under.
- Staff applied a person-centred approach when planning care. They listened to their patients and tried to provide the care and treatment that would work for them. When faced with complexities, for example, due to prison restrictions on medical equipment, they actively sought to resolve them in the patient's best interests.
- Staff offered flexibility in the care and treatment they provided. For example, the substance misuse team responded to requests for additional support from patients who were on a clinical withdrawal programme.
- The social care coordinator supported patients at their appointments with social workers, which helped with encouraging their participation, reducing their anxiety, and articulating their needs.
- Staff recognised the support needs of vulnerable patients, for example, they arranged social care support for a patient with autism who felt vulnerable when going into the communal showers.
- Social care staff advocated for a patient's dignity and right to support when they were offered incontinence aids in place of assistance to get to the toilet. The patient had mobility needs but no continence issues. However, the patient had accepted a waterproof sheet on her bed due to delays in accessing timely assistance out of hours.

Involvement in care

- Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.
- Patients were encouraged to care for themselves. For example, patients received their medicines 'in-possession', which meant they ordered, collected, and administered their own medicines.
- At the time of our inspection, the service had no health or social care peer mentors although a prison peer mentor supported a blood-borne virus group. The drug and alcohol recovery service planned to recruit peer mentors to support their work. Social care staff said they would benefit from social care buddies and were aware of potential applicants. They had discussed this with the prison and were awaiting a decision.

Are services responsive to people's needs?

Access and discharge

- The primary health care service operated Monday to Sunday, from 6.45am to 8.30pm, and had overnight cover provided by 2 qualified nurses. However, the provider told us they were not commissioned to provide a 24-hour service but had started to provide overnight cover following a Prisons and Probation Ombudsman recommendation.
- The service was very busy and received referrals from a range of sources that included reception health screenings, GPs, other healthcare services, and the prison. The service also managed planned and urgent external appointments.
- The team operated a duty system daily to deal with urgent needs and crises. The duty worker also attended to social care needs when the social care coordinator was not present.
- The service held a nurse triage waiting list, however, we found it had multiple uses. For example, we found that some staff used it to list patients requiring periodic checks (such as blood tests every 3 months) while other staff added patients to the list who required appointments booking sooner. We found 2 patients on the list who had been waiting over 2 weeks for an appointment. One patient had asthma-related issues and the other said she was experiencing pain.
- The service used the 'tasks' function on SystmOne to assign tasks, share information, and request action from other staff and services. However, we found these were left to build up due to staff assigning them to individuals rather than to a group or team. There was limited oversight of tasks to check whether they were completed and could be closed. We sampled some tasks, which showed some tasks had been completed but not closed, some had been partially completed, and some still required action.
- Patients completed applications to refer themselves to primary health care services. The system had recently switched from paper to electronic applications, which had inadvertently allowed patients to make referrals to a number of services at the same time. This had generated a huge volume of applications and created a back log for the service of around 1500 applications, resulting in delays of 4 to 5 days for an initial review before being referred to the nurse triage process. During our inspection, the back log had reduced to 63. The prison had reverted to a paper application system while the electronic process underwent review.
- We found the management of external hospital appointments was effective with good administrative and clinical oversight. Healthcare staff worked alongside prison staff who offered 3 planned escorts daily to support external appointments. The service also liaised with the prison to manage urgent appointments. Appointments were rescheduled on those occasions when there were not enough prison officer escorts to facilitate them. Healthcare staff monitored these patients closely and made new appointments as soon as possible.
- The service actively supported the safe discharge of patients with complex needs, which often involved case management involving several agencies and providers. Staff worked with the prison to identify community services, make appropriate referrals, undertake joint assessments, share information, and manage risks. Examples included a patient in hospital requiring transfer to a prison with suitable facilities or a nursing home; and liaising with a local authority to arrange a Care Act assessment of a patient's support needs on release.
- The clinical substance misuse service was available Monday to Sunday during day times with weekend shifts covered by healthcare assistants. The service accepted referrals from any source with most patients being identified at reception health screening.

Are services responsive to people's needs?

- The service reviewed all new receptions to identify patients with substance misuse issues and visited them promptly. The clinical service had clear pathways for patients needing detoxification. At the time of our inspection, the clinical service had no waiting lists.
- The team worked flexibly to manage the demands of the changing population that comprised prisoners on remand, prisoners with long and short-term sentences, recalled prisoners, transferred prisoners, those identified for early release. They ensured immediate access to treatment for those patients who were on prescribed medicines on arrival, and prompt initiation of detoxification for those with drug or alcohol dependency.
- The clinical team worked flexibly and diligently to ensure that all patients received timely care and treatment. They regularly faced delays to their monitoring and observation checks due to lengthy medicines rounds, or prison issues that prevented access to patients' cells.
- Discharge planning was effective despite the numerous challenges the service faced. The service aimed to offer all patients being discharged follow up services in the community with appointments made. The recovery team liaised with the local teams to follow up patients. This involved liaising with many local authorities and community providers. For example, in quarter 3 (October to December 2023), data we reviewed showed that 96% of patients had planned discharges to 33 different local authorities in England, as well as 55 patients discharged to areas outside England.
- The team arranged for patients to receive Naloxone on discharge. Naloxone is a medicine used to reverse or reduce the effects of overdose by opioid drugs.
- A social care coordinator was available from 8.30am to 3.45pm Monday to Friday and oversaw all social care referrals. There were arrangements in place to ensure that social care needs were identified and timely referrals made in her absence.
- Comprehensive reception screening identified any social care needs and referred patients to the social care coordinator, who aimed to see them within the same or next working day.
- The service had developed an effective social care pathway with Cheshire East Local Authority. This included clear referral, assessment and care planning processes, which worked well. Staff made referrals to the local authority where they identified a potential social care need. Referrals typically resulted in a social work assessment of care needs or an occupational therapy (OT) assessment of the need for aids and adaptations. The OT pathway was fairly quick with patients receiving equipment promptly. Social work assessments often took longer but there were effective arrangements in place to mitigate risks to patients; staff developed a brief support plan and provided care to patients.
- Staff and the local authority worked together to plan safe discharges for patients. Local authority staff attended handover meetings, completed assessments, liaised with housing agencies and made arrangements for other local authorities.

Facilities that promote comfort, dignity and privacy

- Most primary health care services were provided from a designated healthcare building, which held offices, clinic rooms, a pharmacy and medicines administration points. Clinical substance misuse team staff were based in a nearby portacabin that accommodated the mental health team, where they had access to a clinic room and meeting rooms. Some services were provided from Waite wing, which had clinic rooms and medicines administration points.

Are services responsive to people's needs?

- The building, space and facilities were not sufficient for healthcare's needs. For example, during our inspection, we saw patients standing or sitting on the stairs, queuing in the corridors, or waiting outside due to limited space and facilities in the healthcare building. Staff across healthcare told us there were not enough rooms for their clinics and therapies. The pharmacy and medicines administration points were small and cramped. The clinical and recovery substance misuse teams could not be co-located, which had an impact on integrated working affecting communication, information sharing, peer support and case discussions.
- Work was due to start on the building of a new healthcare unit in August 2024, with a completion date of early 2025, which would offer improved facilities.
- The prison had two accessible cells for patients who needed ground floor accommodation based on the Valentina and Waite wings. There was very little ground floor accommodation available in the house blocks.
- Patients were encouraged to maintain their independence, with support where needed. They had access to mobility aids, equipment and adaptations subject to a social care or occupational therapy assessment.

Meeting the needs of all people who use the service

- The primary care team offered a range of clinics led by GPs, nurses or healthcare support workers that included long-term conditions and health checks. They made secondary care referrals where needed and tracked their progress, helped by their good working relationships with the local hospital.
- Clinical substance misuse staff worked closely with the recovery workers to offer a range of clinical and psychosocial interventions, tailored to patients' individual needs. For example, recovery workers offered 1 to 1 sessions, groups, self-help booklets and a range of information and resources. They provided sessions in the healthcare unit, on wings and house blocks, and in other settings such as the chaplaincy.
- Staff identified vulnerable patients and ensured they received the assistance and equipment they needed to help them stay safe and maintain their independence.
- We found good examples of support tailored to patients' individual needs. One anxious patient needed support to attend the communal shower room. A patient with limited mobility needed flexibility in the support offered to help them get to the toilet.
- Staff told us that some patients could benefit from low-level social care support from peers but the prison did not have such a peer support scheme.

Listening to and learning from concerns and complaints

- The provider had a complaints policy that set out how it handled complaints. The provider had 3 levels of complaints – concerns, informal complaints and formal complaints, with processing time frames attached.
- Patients knew how to complain. In the 12 months from April 2023 and March 2024, the service received 4 concerns, 101 informal complaints and 6 formal complaints. The most complained about issue was access to treatment and medication. We reviewed a random sample of 5 complaints and responses sent to patients. We found these were not dealt with in a timely manner, and 3 submitted in October and November 2023 remained unresolved.

Are services responsive to people's needs?

- The provider analysed the complaints they received to identify themes and any lessons learned. They shared their findings with healthcare and prison staff. They worked collaboratively with the prison to identify solutions to any prison-wide issues such as access to medicines administration rounds.

Are services well-led?

Leadership

- The health care service lacked stable and consistent leadership having experienced several changes of managers in the last few years. Staff we spoke with said that the changes and uncertainty did not help when working in an already challenging environment.
- At the time of our inspection, the health care service was led by a temporary head of healthcare, who had been in post for around 9 months, and was due to leave in the coming weeks. The provider told us they intended to appoint another interim head of healthcare as soon as possible.
- The provider had assigned the registered manager role to an experienced manager who had recently obtained a regional role overseeing healthcare in several prisons. Although they were limited in how much time and support they could offer healthcare at HMP Styal, they had quickly become aware of the issues in healthcare and showed strong motivation to make the service improvements needed.
- Leaders and managers across the prison and healthcare recognised the need to work together to deliver their respective functions safely and effectively. The prison had a dedicated health link governor who met with healthcare managers every 2 weeks.

Vision and strategy

- Staff were aware of the provider's corporate vision and values but did not think that these were evident in their service.
- NHS England and His Majesty's Prison and Probation Service (HMPPS) had set up a transformation board that oversaw a prison-wide improvement programme, but this had been placed on hold temporarily.
- The provider had been aware of the issues in the healthcare service and had developed improvement plans that they monitored through their own internal enhanced surveillance process. They had also provided regular updates to the transformation board.
- During our inspection, we found a renewed commitment between the provider, commissioners, and prison governors to work collaboratively to improve the service. We were told that the transformation programme had been updated and expanded and that the transformation board would be restarting with a meeting scheduled in the coming weeks.

Culture

- Staff morale varied and very few of the primary health care staff we spoke with said they felt supported and valued. The concerns they raised varied from workload pressures to a culture of bullying. Staff did not feel confident to raise concerns, or they felt their concerns were minimised, or not addressed at all. Some staff in the primary care service told us they were thinking about leaving for various reasons including stress, lack of support, staffing shortages, and an unsupportive culture.
- During 2023, the provider had undertaken a review of the culture in healthcare and taken actions, including investigating bullying allegations, consulting all staff, and developing an action plan. However, staff were unsure if the provider had correctly identified the root causes of the problems in the service and said they had not seen much change in the workplace.

Are services well-led?

- Staff in primary healthcare were under a lot of pressure due to staffing gaps. Nurses had to prioritise clinical duties, which left them little time to do their governance tasks such as audits and supervision. Staff told us that they had experienced the same issues for a long time and had not seen any improvements. Staff told us they felt unsupported.
- Staff in primary healthcare and other teams told us that new staff came and went because they were ‘thrown in at the deep end’ and were not supported sufficiently. During our inspection, we saw staff visibly upset and stressed. Even so, they showed a strong commitment to their colleagues and patients and worked hard to provide a full service in challenging circumstances.
- Staff from other teams told us that primary care staff were, “Run ragged and tired, faced with pressures every day,” with the service dealing with unpredictable staffing levels and relying heavily on temporary staff.
- The prison governor had concerns about primary healthcare that included staffing levels, inconsistencies in service delivery, and the heavy reliance on temporary staff, all of which affected the stability of the service.
- Staff in the substance misuse service described their team as cohesive and supportive. They felt confident to raise any issues and receive responses. They described a team of passionate staff delivering a consistent service.

Governance

- The provider had governance arrangements to manage quality and safety that included an operational structure and systems and processes to support oversight of service delivery. These included an audit programme, quality checks, and the Registered Manager’s Toolkit. We found these were not always applied effectively and therefore did not provide sufficient assurance of service quality. This was partly due to the staffing pressures the service faced and the need to prioritise clinical activities and patient care. However, we also found examples of completed checks and audits that had failed to identify issues associated with infection prevention and control and medicines management. We found an action plan completed following an infection control audit in January 2023, which identified issues many of which remained unresolved.
- Managers regularly attended a range of governance meetings such as the local delivery board, the integrated governance meeting, HMP Styal senior management team meeting, NHSE quality and contract meeting, and drug strategy meeting. These meetings gave them the opportunity to share issues and concerns, identify actions and monitor progress.
- The provider had policies and procedures to cover the full range of healthcare activities and functions. However, these were not always followed at local level. For example, we found concerns with medicines management practices, in-possession risk assessments, infection control standards, and record-keeping.
- The provider had mandatory training and supervision requirements for staff, however, we found not all staff had completed life support training, and staff had not received clinical supervision for some time.

Management of risk, issues and performance

- During our inspection, we found the primary health care service to be in a fragile state. We identified a number of risks that had an impact on the safe and effective delivery of care and treatment. The provider had already identified many of the risks and added them to their risk register.

Are services well-led?

- During 2023, the provider had recognised concerns with their service model and staffing levels, and questioned whether they were adequate to meet the health and social care needs of the women in the prison. They had shared their concerns with commissioners. In the meantime, they had estimated minimum safe staffing levels and funded additional staffing posts. Recently, they had submitted business cases to commissioners for additional funding and resources across healthcare.
- Commissioners had been monitoring the service closely and were working with the provider to improve the service. They had undertaken a workforce review and a pharmacy review, updated the health and social care needs assessment, and asked the provider to develop a workforce strategy. The provider had developed a comprehensive transformation plan with support from commissioners and the prison governor. This was overseen by a multi-disciplinary transformation board that was due to restart with a meeting scheduled for mid-May 2024. In response to the ongoing recruitment and retention challenges, the provider had recognised they needed a more vigorous and strategic approach and had developed a new 'attraction, recruitment and retention' strategy.
- Healthcare activities had an impact on the prison regime and vice versa. Healthcare managers and the health link governor discussed their main issues and risks at 2-weekly meetings and tried to identify solutions. The main issues for the prison were the delayed starts to, and the length of medicines administration rounds; and healthcare appointments being booked without taking into account (where feasible) patients' work and education schedules. Healthcare described delays to patients being brought to medicines points by officers, which needed to be done one house block at a time.
- The provider gathered a wide range of useful data about the service, for example, clinic non-attendance rates, cancelled external appointments, waiting lists, caseloads, complaints, and incidents. However, during our inspection, we found that data was not always accurate or reliable due to poor recording practices, for example, we received a data extract on the number of patients receiving insulin and other critical medicines, which did not match the actual number of patients on those medicines.
- The service collated and submitted performance data in line with national and contractual requirements. We reviewed the substance misuse service's National Drug and Alcohol Treatment Monitoring System (NDTMS) performance data, which showed good outcomes comparable or above other prisons.

Learning, continuous improvement and innovation

- The provider was already aware of some of the issues we found during our inspection from their own investigations and from concerns raised by some stakeholders including commissioners, the Independent Monitoring Board (IMB), and the prison governors.
- The key parties involved showed a renewed commitment to making sustained improvements across the prison. The new governor had met commissioners and senior managers from Spectrum to discuss the need for a collaborative approach towards transformative change. Staff were encouraged by the momentum shown and were keen to see results.
- A new healthcare unit was due to be built with a start date of August 2024, and a completion date of early 2025. The plans included a new pharmacy and improved facilities.
- The substance misuse team was supporting a prison initiative to provide naloxone nasal spray to all house blocks and wings, and for prison officers to be trained in their use.

Are services well-led?

- The local authority staff who regularly visited the prison had applied to be listed on the prison's regular visitors list. This meant that the staff would have easier access to the prison, which would help minimise delays to patients' assessments.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider failed to provide care and treatment in a safe way to service users.</p> <p>The provider failed to ensure that risks to service users were adequately assessed and action taken to mitigate any such risks.</p> <p>The provider failed to ensure the proper and safe management of medicines.</p> <p>The provider failed to ensure adequate infection prevention and control standards.</p> <p>Enforcement action we took: We issued a Warning Notice.</p>
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider failed to maintain effective scrutiny and oversight of the service.</p> <p>The provider failed to assess, monitor and improve the quality and safety of the services provided.</p> <p>Enforcement action we took: We issued a Warning Notice.</p>
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p>

This section is primarily information for the provider

Enforcement actions

The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled, and experienced staff deployed to meet the needs of service users.

Staff did not receive the appropriate support, training and supervision as is necessary to enable them to carry out their duties.

Enforcement action we took:

We issued a Warning Notice.