

Avon and Wiltshire Mental Health Partnership NHS Trust

HMP Bristol

Inspection Report

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Overall summary

This inspection was an announced focused inspection on 26-27 June 2018, under Section 60 of the Health and Social Care Act 2008. The purpose of the inspection was to follow up on Requirement Notices that we issued following a joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in March 2017, and to check that the provider was meeting the legal requirements and regulations associated with the Act.

This report covers our findings in relation to those aspects detailed in the Requirement Notice dated 25 July 2017 in the joint HMIP/CQC report, in respect of Regulation 9 Person Centred Care.

Our inspection team

This inspection was completed by two CQC health and justice inspectors.

During the focused inspection, we reviewed the action plan created by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), which demonstrated how they have worked to achieve meeting compliance with the requirements. We spoke with staff and looked at a range of documents and records relating to clinical practice and governance.

Background

HMP Bristol is a category B local prison holding male prisoners. The prison is a mixture of Victorian and later 20th-century buildings, situated in a residential area of the city.

AWP provides a range of primary healthcare services to prisoners at HMP Bristol, comparable to those found in the wider community. The location is registered to provide the regulated activities: Treatment of disease, disorder or injury and diagnostic and screening procedures.

CQC inspected this location with HMIP between 13 and 16 March 2017. We found evidence that fundamental standards were not being met and issued a Requirement Notice in relation to Regulation 9, Person Centred Care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The joint report published following the March 2017 inspection can be found by accessing the following website:

<https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/07/Bristol-Web-2017-2.pdf>

We subsequently asked AWP to make improvements regarding the breach. We checked these areas during this focused inspection and found the provider had addressed the previous regulatory breach identified.

Summary of findings

In our Requirement Notice issued in July 2017, we referred to the “Brunel unit” as an “in-patient unit”. The Brunel unit is an area of the establishment where the prison accommodates some prisoners with more

complex needs, it is not an inpatient-unit and the healthcare team do not independently place people onto this unit. However, healthcare staff do routinely visit prisoners on the unit.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?

We did not inspect the safe key question in full at this inspection. We inspected only those aspects detailed in the Requirement Notice issued in July 2017 as a result of the joint inspection with HMIP in March 2017.

At this focused inspection, we found the provider had taken adequate action to address the risks identified in March 2017. The mental health service was appropriately promoted, advertised and accessible. Staff assessed patients promptly so support was not unduly delayed. Patients all had detailed, individualised care plans in place and staffing levels were good.

Are services effective?

We did not inspect the effective key question at this inspection.

Are services caring?

We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive key question at this inspection.

Are services well-led?

We did not inspect the well-led key question at this inspection.

Are services safe?

Our findings

At our previous inspection in March 2017, we found that the provider did not have processes in place to help ensure patients individual needs were identified and met.

These included:

- Primary mental health care was not sufficiently promoted, advertised or accessible.
- Prompt assessments did not always take place, meaning access to therapy was delayed. This impacted on the safe care and treatment patients received.
- Patients placed on the Brunel unit had minimal therapeutic input due to low staffing numbers.
- There was a lack of formal care plans in place for people with ongoing mental health needs. This meant their individual care and treatment needs may not have been identified and as a result, there was a risk to them not receiving appropriate care and support.

At this focused inspection, we found that AWP had taken appropriate action to address these risks and help ensure patients received personalised care and treatment that met their needs.

We found that the mental health service was well advertised and promoted within HMP Bristol. AWP had introduced a new model for the mental health service, this had been embedded in practice and had helped improve outcomes for those who used the service. AWP provided a seven-day service and although staff were not on site overnight, an on-call manager was available to support primary health care or custody staff when required. Primary mental health services were explained and discussed with prisoners during the reception and induction process. This included details on how they could self-refer into the service. Healthcare staff identified prisoners who required a mental health assessment during the reception process and appropriate referrals were made to the mental health team. We saw evidence that GPs and the mental health team completed mental health assessments promptly following referral.

There was a shift co-ordinator assigned each day who helped ensure all initial Assessment, Care in Custody and Teamwork (ACCT) reviews were attended by a team member. ACCT is a prisoner-centred, flexible care-planning system which, when used effectively can support those identified as at risk of suicide or self-harm. The co-ordinator would assign appropriate staff to attend subsequent ACCT reviews for those on the mental health caseload.

The shift co-ordinator also helped ensure patients who required urgent support were seen promptly. They managed the referral process, supported staff with accessing information about patients and made sure all the care provided and decisions made were well documented.

The mental health team conducted group work on a regular basis. At the time of the focussed inspection there were 44 patients waiting to participate in a programme with an anticipated wait of five to seven weeks. The prison regime and issues with prison staffing frequently impacted upon group and clinic cancellations. The team mitigated this through use of guided self-help work, which was provided often alongside therapeutic work with allocated workers on a one to one basis. We reviewed a sample of cases and saw that all patients referred with non-urgent needs had been seen within two weeks.

Patients held on the mental health team caseload all had formal care plans in place. Care plans we looked at were detailed, personalised and demonstrated the work completed to improve outcomes and help keep patients safe. We saw and staff told us there were sufficient levels of healthcare staff. This meant the work outlined in care plans was completed in a timely manner and met need.

Prisoners who were living on the Brunel unit that required support from the mental health team all had formal care plans in place. We found evidence that staff adhered to these care plans and fully supported their patients to help ensure their care and treatment needs were met.

Are services effective?

(for example, treatment is effective)

Our findings

We did not inspect the effective key question at this inspection.

Are services caring?

Our findings

We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect the responsive key question at this inspection.

Are services well-led?

Our findings

We did not inspect the well-led key question at this inspection.