

HMP Chelmsford

Inspection report

HMP / YOI Chelmsford
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2018
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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 summary

We carried out an announced focused inspection of healthcare services provided by Essex Partnership University NHS Foundation Trust at HMP Chelmsford between 23 and 25 October 2018.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons in June 2018, we found that the quality of healthcare provided by the trust at this location required significant improvement, and we issued a warning notice to the trust under section 29A of the Health and Social Care Act 2008.

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

We do not currently rate services provided in prisons.

At this inspection we found:

- The systems for secondary health screenings and sexual health were much improved.
- Whilst some improvements had been made, medicines were not managed safely and consistently.
- Further work was required to ensure the effective management of mental health patients and ensure personalised care plans were in place for all patients.
- Significant improvements had been made to the complaints system, however responses were not always timely and recording needed to be improved.
- Governance systems had improved since our last inspection and staffing challenges were well managed.
- Lessons learned from incidents and complaints were not widely shared to enhance service delivery.

Our inspection team

Our inspection team was led by a CQC health and justice inspector, accompanied by the manager of the health and justice team, a second health and justice inspector, a hospitals inspector and a CQC pharmacist specialist.

Before this inspection we reviewed a range of information that we held about the service. Following the

announcement of the inspection we requested additional information from the trust, which we reviewed. During the inspection we asked the provider to share with us further information, we spoke with healthcare staff, prison staff, commissioners and people who used the service, and sampled a range of records.

Background to HMP Chelmsford

HMP & YOI Chelmsford is a local Category B male adult and young offenders institution. The prison is located in the city of Chelmsford, England and accommodates up to 745 adult prisoners and young offenders. The prison is operated by Her Majesty's Prison and Probation Service.

Essex Partnership University NHS Foundation Trust (EPUT) provides health and social care and clinical substance misuse services at the prison. Essex

Partnership University NHS Foundation Trust is registered with CQC to provide the regulated activity of Treatment of disease, disorder or injury at the location HMP Chelmsford.

Our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) was in June 2018. The joint inspection report can be found at:

<https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-yoi-chelmsford/>

Are services safe?

Risks to patients

At our last inspection we found that following a prolonged absence of suitably skilled staff, sexual health clinics did not meet patient need.

- At this inspection we found that a new system had been implemented to monitor sexual health referrals and patients were offered sexual health testing during their initial health screening. Test results were delivered in a timely and confidential manner; 27 patients were awaiting test results at the time of our inspection, while three patients were awaiting a sexual health test. Sexual health clinics were now running regularly in which patients could access screening as well as treatment for identified conditions. Condoms were also available for patients.

Information to deliver safe care and treatment

At our last inspection we found that staff did not have the information they needed to deliver safe care and treatment:

- There was no effective system to monitor and ensure that secondary health screenings to identify all health and social care needs were completed within the required 72 hour timescale.
- There was no system in place to ensure that patients received adequate support prior to their release from the prison.
- There was no clear mental health pathway.
- Systems to monitor referrals and the timeliness of assessments were not effective.

At this inspection we found that:

- Systems were in place to ensure all patients received a secondary health screening within 72 hours of arriving at the prison. These appointments were carried out in a confidential treatment room and patients who did not attend were followed up in a timely manner and invited to another appointment. Sexual health screening and Blood Borne Virus (BBV) testing was carried out during the secondary health screen, which was good practice.
- Patients due to be released from the prison received a supply of prescribed medicines prepared by the pharmacy team. Patients were not currently supported

to register with a GP on release, or provided with medical information to take with them. Both the healthcare provider and the prison were sighted on this and work was underway to make improvements.

- The patient pathway for people with mental health needs had improved, however discussions about individual patients' risks were not always documented.
- Waiting lists for the mental health service were monitored to detect and respond to changes in level of risk; however the timeliness of ongoing appointments was not monitored.

Appropriate and safe use of medicines

At our last inspection we found that the provider did not have reliable systems for appropriate and safe handling of medicines:

- The recording template for the monitoring of fridge and room temperatures did not identify and mitigate risks to the integrity of stored medicines.
- Systems for managing stock medicines did not support staff to reduce the risk of patients receiving incorrect medicines.
- Administration of prescribed medicines on A and B wings was unsafe and posed a risk of patients receiving incorrect medicines.

At this inspection we found that:

- Temperatures in clinical rooms were appropriately monitored; however the fridge in the records room was out of range on two of the three days of our inspection. Senior managers advised that action was taken to address this immediately following our inspection.
- Named patient medicines were now stored in individual named containers which meant that stock medicines were kept to a minimum and the risk of patients receiving incorrect medicines was reduced. Opened liquid medicines did not have their revised expiry date documented. Once opened, the effectiveness of medicines may be reduced earlier than the original expiry date.
- A new treatment room on B wing was opened shortly prior to our inspection. The administration of medicines for patients on A and B wings was now conducted from the new treatment room, which ensured medicines were administered safely.
- Patients' night medicines were prepared by pharmacy technicians during the day and placed in folders. One

Are services safe?

folder contained a loose tablet with no corresponding administration information for staff, which created a risk that patients may not receive their medicines as prescribed.

- Folders containing night medicines were stored in a records room which was unlocked during the first two

days of our inspection. This was highlighted to managers during our inspection and a reminder was placed on the door for staff to keep the room locked at all times.

Are services effective?

Effective needs assessment, care and treatment

At our last inspection we found that the Care Programme Approach (a package of care for people with enduring mental health needs) was not clearly understood or managed by staff in order to care for patients effectively.

- Staff were unable to easily identify those patients on the Care Programme Approach (CPA) caseload.
- Care planning was not meaningful or personalised for patients with mental health needs to ensure that they received appropriate care and treatment.

At this inspection we found that although improvements had been made, the management of patients under the CPA required further development:

- Since our last inspection, staff had received CPA training, which agency staff were also able to access; however doctors had not received this training. Staff

were able to clearly identify those patients on the CPA caseload however an audit of five CPA patient records carried out by the provider in October 2018 identified that further work was needed to bring the service to the required standard.

- All 16 patients managed under CPA at the time of our inspection had an allocated case worker. We saw evidence that staff communicated with community mental health teams; however further work was required to ensure patients managed under CPA were fully supported on release from prison.
- We reviewed care plans for seven patients managed under CPA and found that two did not have a care plan in place. Whilst care plans were present for the majority of patients, some contained limited information and work was required to ensure personalised care plans could be evidenced for all patients.

Are services caring?

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

Are services responsive to people's needs?

Listening and learning from concerns and complaints

During our inspection in June 2018 we found that the complaints system was not accessible to patients and the management of complaints was poor:

- The complaints policy had not been sufficiently adapted to ensure it was fully effective in the prison environment.
- Complaints information did not effectively encourage or enable patients to make a complaint about healthcare services.
- Patients were not aware of the need to complete a specific healthcare complaints form to protect their confidentiality.
- Details of some complaints had been entered into patients' clinical records.
- All complaints about the clinical substance misuse service were managed by the prison with no oversight or monitoring by the provider.

At this inspection we found that there had been significant improvement to the management of complaints:

- A revised policy and protocol was in place that better reflected the prison environment. Some clinical staff had received training in complaints management and staff were supported to take ownership of individual complaints, seek informal local resolution of 'concerns' and record the outcome.

- Leaflets, which invited compliments, comments, concerns and complaints had been simplified, and were available in languages other than English. Revised information about the 'We want to hear from you' process was available in some areas.
- Healthcare complaint forms were available in most areas. We looked at a sample of 90 concerns received between September and October 2018 that had been resolved locally. We found that the majority (49) were submitted on healthcare forms. Those submitted to the prison reached the healthcare team in a timely way so, although not sufficiently confidential they were received by the trust promptly.
- The practice of recording 'complaints' in patients' records had ceased; however, we saw some appropriate reference to the local resolution of concerns that related to actions involving clinical activity. These entries were written sensitively to avoid future discrimination.
- The revised recording and monitoring arrangements for complaints had been extended to the substance misuse team to promote confidentiality and ensure that the trust received complete information about their services.

Are services well-led?

Leadership capacity and capability

At our last inspection we found that oversight and leadership of the service required significant improvement:

- Leadership of the service was weak, contributed to by senior manager vacancies and a lack of supervisory support.
- The ineffective oversight and deployment of staff was adversely impacting on the delivery of care and treatment.
- There was no effective oversight of the mental health service.

At this inspection we found that the provider had made some significant improvements to the leadership of the service:

- A designated supervisor had been identified for the head of healthcare and two supervision meetings had taken place since our last inspection. Regular meetings between the head of healthcare and the prison's deputy governor had improved partnership working. A primary care lead had been recruited and a mental health lead vacancy was currently out to advert with a long term agency manager covering this vacancy in the meantime.
- Whilst recruitment remained a challenge and the provider had a high number of staff vacancies, the oversight and deployment of regular agency and bank staff was much improved and agency and bank staff were able to access provider training. Managers regularly updated the service risk register demonstrating oversight and monitoring of risks to the quality and safety of the service and patients as a result of staffing difficulties.
- The oversight of the mental health service had improved which was improving patients' experience. Staffing difficulties within the team were more effectively managed and mental health nurses were no longer required to support the daily administration of medicines. Improved joint working relationships with prison staff had enabled the service to become proactive and effective in the management of patients' needs, rather than reactive.

Managing risks

At our last inspection we found that the oversight of incidents was ineffective, meaning some risks to patients were not identified or investigated properly. At this inspection, managers had an improved oversight of

incidents reported by staff and incidents were investigated appropriately in a timely manner. However there was little evidence of lessons learned recorded, or that lessons learned were being shared with the staff team to improve the quality and safety of services.

At our last inspection we found that the recording and monitoring of complaints was not sufficiently systematic to enable the identification of trends, or review the timeliness or quality of responses:

- Complaints which the provider's policy indicated should be resolved locally were not consistently logged and the local resolution monitoring form was not routinely completed.
- Complaints records were not systematically monitored.
- Learning from complaints was not well developed.

At this inspection we found that the recording and logging of concerns and complaints had improved since June 2018; however analysis of themes and the systematic sharing of learning from complaints was not well developed:

- We reviewed a sample of 90 concerns records, the local concerns log and the trust level local resolution database and found discrepancies that indicated that they were not being monitored adequately.
- From the sample of concerns we reviewed we found that most responses covered all the issues raised by the complainant, with only six not meeting this requirement. However, as records included only a summary of the conversation to reach local resolution, we could not be certain that this was the case.
- We identified 41 concerns recorded that had not been responded to within the stated 10 days for local resolution. When we looked at the local log of concerns we found significant gaps in recording that made it difficult to monitor the timeliness of responses. The trust database recorded only the date of receipt of the completed complaint. Managers acknowledged that the timeliness and the quality of responses was not being sufficiently monitored or used to make improvements.
- The 'lessons learned' section of the local and trust-level resolution logs was not always completed. Although we were told that complaints were discussed at a range of meetings, we found limited evidence that learning was shared with staff. We saw references to complaints in some key meeting minutes but very limited information to support further learning or improvement.

Are services well-led?

Engagement with patients

At our last inspection we found that patient feedback was not collected, analysed or used systematically to drive improvements to the quality and safety of the service. At this inspection we found that:

- The provider had reviewed the local arrangements for obtaining feedback from patients on their experiences of receiving healthcare services. Some progress had been made in implementing new arrangements; however these were at an early stage and not fully embedded; therefore there was very limited evidence of their impact.
- With support from the prison, credible efforts had been made to introduce a regular forum to gain feedback on

patients' experiences of healthcare services. A short list of relevant issues had been drafted for discussion but an inaugural meeting had been cancelled due to prison operational issues. Staff were considering how they could link into other meetings, such as the Safer Custody Forum, as an alternative to a bespoke healthcare forum.

- The June 2018 Friends and Family Test (FFT) survey had been completed and the results analysed but, although largely positive, the low number of responses limited learning. The FFT survey had since been adapted to make it more relevant to the prison population and a second survey had commenced. We were advised that the trust was looking to see whether the FFT questionnaire could be translated.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met... The provider had not identified or addressed failings regarding the safe storage of medicines within a records room; The temperature of the fridge in this room was out of range during two of the three days of our inspection. The room was unlocked during two days of our inspection, leaving patients' dispensed night medication stored insecurely. Folders used to store patients' night medication were not adequately maintained; one folder contained a loose tablet with no corresponding administration information for staff which created a risk that patients may not receive their medicines as prescribed. The provider's monitoring systems and processes did not enable them to identify where the quality and/or safety of medicines management were being compromised. Recording systems relating to patients' care and treatment were not routinely monitored; There was no effective system to monitor waiting times for mental health appointments beyond a patient's initial assessment. Daily handover meetings to review mental health case- and workloads were not documented to support quality/safety monitoring. Multi-Disciplinary (MDT) meeting records did not fully capture patients' risk management information. Learning from complaints was not well developed with limited evidence that learning was shared with staff. Complainants' feedback was not recorded appropriately in order to be analysed and used to drive improvements to the quality and safety of the service. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.