HMP Forest Bank

Quality Report

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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.

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Overall summary

We undertook a focused inspection on the 24 and 25 October 2017 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 previous focused inspection in December 2016 and to check that the provider was meeting the legal requirements and regulations associated with the Act.

Our key findings were as follows:

Summary of findings

- The provider had reviewed the staffing arrangements and how staff were deployed within the inpatient unit and this ensured adequate cover was available at all times.
- Attendance rates at health assessments had improved significantly which meant that patients had a full health care assessment including mental health at the point of reception into the prison.
- An overarching governance framework supported the delivery of care. However waiting times for primary mental health services remained high and patients with mild to moderate mental health issues did not always have their needs met in the most effective and responsive way.
- The majority of nursing staff told us they felt better supported by senior managers than previously and joint working between clinical leads had significantly improved.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We did not inspect the safe key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in December 2016.

- Since our last inspection we found the provider had reviewed the staffing arrangements and how staff were deployed within the inpatient unit and this ensured that adequate cover was provided to meet patients' needs.

Are services effective?

We did not inspect the effective question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in December 2016.

- Attendance rates at health assessments had improved significantly which meant that patients had a full health care assessment including mental health at the point of reception into the prison. This meant that healthcare staff were better able to plan to meet patients' needs.

Are services caring?

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

Are services responsive to people's needs?

We did not inspect the responsive key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in December 2016.

- Patients waited too long to access a primary mental health assessment and subsequent follow up which was a significant concern.
- Patients with mild to moderate mental health issues did not have access to planned ongoing responsive treatment that met their needs.
- Patients had access to written information and computer technology that assisted them in making and submitting a complaint.

Are services well-led?

We did not inspect the well-led key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in December 2016.

Summary of findings

- An overarching governance framework supported the delivery of care. This included a programme of continuous clinical and internal audits to monitor and make improvements in the service. However waiting times for primary mental health services were not effectively monitored and remained high.
- The service proactively sought feedback from patients and there were plans to take action on the feedback to make improvements in the service.
- The majority of nursing staff told us they felt better supported by senior managers than previously.
- Joint working between clinical leads had improved.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Ensure that patients have timely access to effective and responsive mental health services including a range of interventions and treatments.

Action the service SHOULD take to improve

Continue to identify prisoners with a learning disability at the point of their reception into the prison and develop a patient pathway that effectively identifies their needs and the support they may require.

HMP Forest Bank

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC health and justice inspector, accompanied by a second CQC health and justice inspector.

Background to HMP Forest Bank

Forest Bank is a category B local prison in Salford and accommodates up to 1,460 adult convicted and unconvicted prisoners. The prison is managed by Sodexo Limited who are also responsible for the provision of primary healthcare services, primary mental health services, inpatient facilities and substance misuse services within HMP Forest Bank.

The location, HMP Forest Bank is registered to provide the regulated activity, treatment of disease, disorder or injury. CQC inspected healthcare services at the prison in partnership with Her Majesty's Inspectorate of Prisons in February 2016. During that inspection we issued three Requirement Notices. We followed these up in December 2016 and found the provider had made improvements in some areas and insufficient improvement in other areas where regulations had been breached.

In October 2017 we undertook a focused inspection to follow up on the progress the provider had made in meeting previously identified breaches. We found that the provider had met all of the previous regulatory breaches, however we had concerns about the care patients received and subsequently issued a new Requirement Notice for Regulation 9 Person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Why we carried out this inspection

We undertook a focussed inspection 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 an inspection in December 2016 and to check that the provider was meeting the legal requirements and regulations associated with the Act.

The full focused report on the December 2016 inspection can be found on our website at http://www.cqc.org.uk

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a range of information which we reviewed as part of the inspection. We spoke with staff and sampled a range of records. We were on site for two days and during the inspection we looked at provider documents, patient records, spoke with healthcare staff, prison staff and people who used the service.

Evidence reviewed included:

- We spoke with commissioners from NHS England
- We spoke with a range of health care staff, including nursing staff and GPs
- We spoke with a range of operational prison staff and the prison governor and deputy governor
- We reviewed evidence relating to the uptake of health screening
- We reviewed health and justice quality returns information

Detailed findings

- The HMP Forest Bank health and justice deliver plan 2017/2018
- Health Needs Analysis August 2017
- The health care risk assessment October 2017
- Staff supervision records
- Minutes from monthly managers meeting, records of team handover meetings, minutes of the local clinical governance meetings
- Minutes of the health and justice national meeting for Sodexo Limited
- Minutes from the local medicines management meeting

Are services safe?

Our findings

At our previous inspection in December 2016 we had concerns regarding staffing levels on the inpatient unit. During this focused inspection we found that staffing arrangements on the unit had been reviewed and although staffing levels had not increased, the way in which staff were deployed ensured that patients received safe care and treatment.

Monitoring risks to patients

- At our previous inspection in December 2016 we reported that the inpatient unit was staffed by one registered mental health nurse. Nurses told us they were frequently called away from the inpatient unit to see prisoners located on the wings, which meant that 24 hour nursing care was not provided and we were concerned that this put patients on the unit at risk. Since our last inspection we found the provider had reviewed the staffing arrangements and how staff were deployed within the inpatient unit. The primary health care team provided 24 hour clinical cover to inpatient facilities and the wider prison.
- The primary mental health team were based within the inpatient facility; this meant that the team had a greater physical presence. The team provided clinical services to inpatients and a registered mental health nurse was allocated daily to cover inpatient duties. Support to patients with physical health or social care needs was provided by nurses from the primary care team and social care team where appropriate.
- Operational prison staff provided 24 hour cover to healthcare and were responsible for the daily routine within healthcare ensuring all patients had access to showers, exercise, association and activities where identified, including access to the gym. Officers told us that working arrangements with healthcare staff were good and they regularly consulted and took advice from nursing staff about the care of prisoners located on the unit. During the inspection we saw evidence of effective joint working between officers and nursing staff when responding to some patients with complex mental and physical health care needs located on the unit.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in December 2016 we had concerns regarding prisoners non-attendance rates at secondary health screening, which was a comprehensive health assessment that was completed before their location on the wings. When we undertook this focused inspection in October 2017 we found that arrangements in respect of attendance rates at health screening had significantly improved.

Effective needs assessment

- At a previous inspection in December 2016 we found that non-attendance rates for secondary health screening was high. This meant that prisoners health needs were not identified.
- Since our last inspection we found that there had been a significant improvement in the uptake of health screening since March 2017 when a new process was put in place. We found attendance rates were monitored regularly by the lead for primary health care. Information we received showed that in July 2017 100% of prisoners attended a health screen and in September 97% attended. The provider in partnership with the prison ensured that all prisoners had a full health screen before they left the first night centre to be located across the prison. Any prisoners who refused to engage in the process were followed up on their wing location.
- Previously we observed that the initial health screen did not include a learning disability assessment and we were concerned that the needs of people with learning disabilities was not being identified. At this focused inspection we were advised that a project group aimed to identify prisoners with learning disabilities and develop a patient pathway was to be set up. The group would include input from prison, healthcare and education staff with the intention to improve screening for this group of people.

Effective staffing

- At a previous inspection in December 2016 some staff told us they felt unsupported by senior management. During this inspection the majority of nursing staff told us they felt happier and supported by senior management, though mental health nurses reported less favourably. Despite this all staff we spoke with told us they had access to both formal and informal support when needed. We found nursing staff accessed managerial and clinical supervision.
- During this inspection we found that there were better working arrangements between primary health care nurses and mental health nurses. Regular team meetings took place and in the absence of a clinical lead for mental health, mental health nurses joined the primary health care team meeting.
- The team had a vacancy for a mental health nurse and a clinical lead for mental health. Arrangements for the interim management of the primary mental health team had been put in place in the absence of a clinical lead, which ensured that staff were managed and supported to undertake their duties.

Are services caring?

Our findings

We did not inspect the caring key question in full at this inspection

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection in December 2016 we had concerns regarding the length of time patients waited to be seen following a referral to the primary mental health team. We were concerned that patients with mild to moderate mental health needs did not have access to planned ongoing treatment or psychological interventions. At this focused inspection in October 2017, we found patients continued to wait a long time to be seen by the primary mental health team, although emergency and self-harm concerns were responded to in a timely way. Despite regular discussions between the governor, the provider and NHS England to develop an integrated mental health service patients continued to wait a long time to be seen and could not access appropriate treatments. We have shared our concerns about the delay in service development with the responsible service commissioners. However as the service was in the process of being redesigned we decided not to take enforcement action on this occasion, but to issue a Requirement Notice that we will follow subsequently follow up.

Responding to and meeting people's needs

- In December 2016 we found that patients with mild to moderate mental health issues did not have access to appropriate support and treatment to meet their needs. At this inspection we found there had been no change or improvement. Some patients still had no access to input from a psychiatrist or to psychological interventions and prisoners with mild to moderate mental health needs continued to have unmet need.
- At the time of our focused inspection in October 2017 we found that the provider in discussion with NHS England was involved in negotiations to develop an integrated mental health service, which meant that primary mental health services would be delivered by another specialist mental health provider. The process had been complex and negotiations remained ongoing at the time of our focused inspection in October 2017.
- Previously we reported that the inpatient unit lacked therapeutic input. At this focused inspection we found that patients had good access to non-clinical therapeutic input, which included patients completing personalised incentive therapeutic work books and access to communal dining. Patients spoke highly of the benefits of partaking in the empowerment programme that was run by education. However patients located on the unit continued to be unable to access clinical therapeutic input, such as access to psychology services and not all prisoners on the unit could access a psychiatrist.

Access to the service

- In December 2016 we found that patients waited up to six weeks to access the services of the primary mental health team and reported that this was too long. At this inspection we found that there had been some small improvement but patients waited up to four weeks, for a primary mental health assessment, although appointments could be prioritised depending on need. At the time of our inspection there were 66 patients waiting to see a mental health nurse.
- The team was made up of five mental health nurses who provided triage clinics three times a week. Staff told us that due to high demand for the service they were unable to offer regular ongoing support to patients following an initial assessment. Nurses told us they responded to patient referrals, but they had very few treatment options to offer, other than patient self-help literature or a referral to a GP to prescribe medicines. However all incidents of reported self-harm were always followed up.

Listening and learning from concerns and complaints

- In December 2016 we reported that the complaints system was not publicised widely across the prison. Health care information leaflets did not include any reference to how to make a complaint. We were told that the new complaints system was available via the prisoner appointment 'kiosk' booking system. At this focused inspection we found that the complaints system was advertised within healthcare. Complaints literature included information on how a prisoner could complain and how to escalate their complaint if they remained dissatisfied with the outcome of the complaint. We also observed that prisoners could make a complaint via the 'kiosk' system.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our previous inspection in December 2016 we had concerns about governance arrangements and how the service was managed. Overall we found arrangements had significantly improved when we undertook a follow up inspection in October 2017.

Governance arrangements

- Since our last inspection in December 2016 a new registered manager had been appointed as head of healthcare with responsibility for managing all aspects of the service, including primary health care, primary mental health and substance misuse. At this focused inspection we found that since their appointment, a number of new systems and processes had been developed that better supported the day to day delivery of the service, including the appointment of a practice manager to assist. However waiting times for primary mental health services were not effectively monitored and remained high.
- Previously we reported that the service lacked an overarching governance framework which supported the delivery of safe, effective, quality care. At this inspection we found that the service now had a programme of continuous clinical and internal audits that were used to monitor quality and to make improvements in the service. For example, staffing levels and the quality of care provided to the inpatient unit was monitored as was attendance at secondary health assessments, which had significantly improved. We also found that key policies and procedures were now in place.

Seeking and acting on feedback from patients, the public and staff

- Since our last inspection the service had proactively sought feedback from patients' views of the service. They undertook a survey over a seven day period between 16-22 October 2017. It was planned that respondent's feedback would be reviewed and areas for change and or improvement would be monitored and an action plan developed.
- At our previous inspection staff told us they felt unsupported by management. They told us they did not feel involved and included in decisions about how to run and develop the service. At this inspection staff told us they felt better supported, they were kept up to date regarding developments within the team and plans for the service. Though mental health staff were less positive overall, some of this was felt to be due to impending changes including staff possibly moving over to a new employer.

Continuous improvement

- We previously reported that there was a lack of joined up working between clinical leads for primary health care and mental health and effective joint working with other health care providers within the prison was lacking. At this focused inspection we found weekly single point of access meetings were held and attended by all healthcare partners and operational prison staff to discuss patients in the inpatient unit. Managers meetings were held monthly where incidents and corresponding learning and actions were discussed and disseminated. The head of healthcare met weekly with clinical leads to discuss service issues including following up on recommendations and actions from previous meetings. A number of other local and clinical governance meetings took place were leads from pharmacy and GP services attended.
- During this inspection we found that there had been no improvement in the services provided to people with primary mental health needs. Despite regular discussions between the governor, the provider and NHS England to develop an integrated mental health service patients continued to wait a long time for a mental health assessment and could not access appropriate treatments.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Patients waited too long to access a primary mental health assessment and subsequent follow up which was a significant concern. • Patients with mild to moderate mental health issues did not have access to planned ongoing responsive treatment that met their needs.