

# HMP YOI Doncaster

### **Inspection 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.

# **Overall summary**

We carried out a desk based review of healthcare services provided at HMP Doncaster in September 2020. The provider of this service was previously named Care UK Health and Rehabilitation Services Limited but on 1 October 2020 they changed their name to Practice Plus Group Heath and Rehabilitation Services Limited. Throughout this report, the provider will be referred to as Practice Plus Group Health and Rehabilitation Services Limited.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in September 2019, we found that the quality of healthcare provided by Practice Plus Group Heath and Rehabilitation Services Limited at this location required improvement. We issued a Requirement Notice in relation to Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this review was to determine if the healthcare services provided by Practice Plus Group Health and Rehabilitation Services Limited were now 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 found that improvements had been made and the provider was no longer in breach of the regulations.

We do not currently rate services provided in prisons.

At this inspection we found:

- The provider had improved management and monitoring of medicines storage to ensure all medicines were fit for use.
- Systems had been improved to ensure patients obtained their medicines promptly, however a small number of patients had experienced delays to their medicines being administered as a result of off-site prescribing arrangements.
- Staff had been trained in NICE guidance in managing patients with suspected deep vein thrombosis.
- There was clear oversight of medicines prescribing and administration continuity to ensure care was safe.
- The provider had increased staffing in the mental health team to better meet patient needs.
- The mental health and substance misuse teams now worked in a more integrated way with a nurse coordinating care for patients who had both mental health and substance misuse needs.
- A range of monitoring had been introduced to ensure that patient care was timely, safe and effective.

The areas where the provider should make further improvements:

• Fully embed the clinical audit process to ensure that learning is used to improve patient care.

### Our inspection team

This desk-based review was carried out by a CQC health and justice inspector with support from a CQC pharmacy specialist inspector. We did not visit HMP YOI Doncaster to carry out an inspection because we were able to gain sufficient assurance through the documentary evidence provided and a telephone conference with the registered manager.

We reviewed the action plan submitted by the provider to demonstrate how they would make improvements to meet regulatory requirements. The provider also submitted a range of documents to demonstrate improvements in the care and safety provided at HMP YOI Doncaster. Evidence we reviewed included:

- Audits of medicines administration.
- Service data.
- Fridge temperature audits
- Mental health staffing arrangements and developments to improve patient care and access.

We also reviewed information submitted by NHS England commissioners.

We reviewed areas where we had recommended in the 2019 joint inspection report that the provider should make improvements.

### **Background to HMP YOI Doncaster**

HMP & YOI Doncaster is a local Category B male adult and young offenders' institution. The prison is in central Doncaster and accommodates up to 1,140 adult prisoners and young offenders. The prison is operated by Serco.

Health services at HMP YOI Doncaster are commissioned by NHS England. Practice Plus Group Health and Rehabilitation Services Limited is contracted by NHS England to provide healthcare services. Practice Plus is registered with CQC to provide the regulated activities of Diagnostic and screening procedures, and Treatment of disease, disorder or injury at this location. Our last joint inspection with HMI Prisons was in June 2019. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/ inspections/hmp-yoi-doncaster-2/

This desk based review covers our findings in relation to those aspects detailed in the Requirement Notice issued to the provider in January 2020.

# Are services safe?

We did not inspect this key question in full during this desk based review. We inspected areas identified in the Requirement Notices issued in January 2020 and areas where we previously made further recommendations for improvements.

At our last inspection we found that there were areas of care and treatment which required improvement. Assessments of individual patient risks were not always carried out in line with guidance, some patients experienced delays in being administered critical medicines and there was insufficient proper and safe management of medicines.

#### **Risks to patients**

During this desk based review we found that the provider had improved oversight of risks to patients received into the prison and had implemented clear systems to request, monitor and follow up missing community GP records and medicines information.

There were now clear procedures in place to identify patients at risk of deep vein thrombosis and ensure that the risks were managed appropriately.

#### Appropriate and safe use of medicines

We saw clear evidence of improved arrangements to ensure medicines were used safely.

- A record of arrival dates and prescribing information was kept, with clear oversight by pharmacy staff ensuring that most patients did not experience delays in receiving medicines when they arrived at the prison.
- Pharmacy technicians monitored new arrivals and ensured that a reconciliation of each patient's medicines took place in a timely way.
- Missed doses were routinely monitored and followed up to ensure continuity of treatment and ensure problems were rectified promptly.
- Refrigerator and room temperature monitoring arrangements had been improved and pharmacy technicians completed weekly audits to confirm medicines were being stored safely.
- New clear guidance on storage of glucagon (a medicine used to treat severe low blood sugar) in emergency bags had been written and staff made aware, to ensure the integrity of this medicine.

The provider had introduced remote consultations during the Covid-19 pandemic which had increased patient access to GPs, however, the remote prescribing arrangements were not fully embedded, and a small number of patients had experienced delays in accessing their prescribed medicines. The provider was working with partners to resolve these issues.

## Are services effective?

We did not inspect this key question in full at this inspection. We inspected areas identified in the Requirement Notice in January 2020 and areas where we made further recommendations for improvements. At our 2019 inspection mental health interventions and support for patients did not meet the demand and there were significant vacancies in the mental health team.

#### Effective needs assessment, care and treatment

The provider had improved the effectiveness of care and treatment for patients with mental health needs.

- They had obtained additional funding from NHSE commissioners to increase mental health provision.
- Two staff provided duty cover each day, with seven day cover and short waits for assessment. The mental health team was now integrated with the substance misuse team so that patients with mental health and substance needs could be supported appropriately through a coordinated approach.
- Whilst the Covid-19 pandemic had reduced opportunities for group work, individual support had continued and new psychology staff had developed a range of in-cell materials to support patients whilst lockdown reduced regime activity.
- A programme of group work sessions had been developed for implementation when it becomes safe to recommence group work. These included emotional regulation, sleep hygiene, self-harm protective techniques, hearing voices and managing guilt.

The provider had also ensured there was good access for patients to healthcare professionals during the pandemic and while the regime was significantly reduced. This included both telephone and face-to-face appointments with all clinicians.

#### Monitoring care and treatment

A range of audits and monitoring processes had been implemented since our inspection in September 2019. These included:

• Routine monitoring of reception screening information, community GP summary care records and community prescribing information.

- Medicines storage and administration audits.
- A review of care for patients at risk of deep vein thrombosis, although this had yet to be developed to ensure learning was fully implemented.
- Routine monitoring of applications for mental health support and weekly multi-disciplinary review meetings.
- A daily senior management meeting took place, including primary, mental health, substance misuse and social care leads. This reviewed care for all new arrivals to ensure that care was being provided in accordance with local and national requirements.
- Management monitoring of all access data and appointment attendance, particularly during the lockdown period. Data showed clearly that patients continued to have good access to healthcare during lockdown. Data demonstrated that face-to-face appointments remained available, and more appointments were undertaken face-to-face than via the telephone during July and August 2020.

#### **Effective staffing**

Practice Plus Group Health and Rehabilitation Services Limited had recruited new mental health staff and the team now consisted of a psychiatrist, four senior mental health nurses with one vacancy; a learning disability nurse, two assistant psychologists, a psychological wellbeing practitioner and an occupational therapist. They had also introduced a nurse with substance misuse and mental health training. A healthcare assistant had also been recruited, and was due to take up their post imminently

- A nurse skilled in mental health and substance misuse supported patients' dual focused care, and could signpost patients into cognitive behavioural therapy sessions, psychosocial or psychology sessions and peer support in addition to one to one work.
- Staff were positive about the positive impact on patient care from the integration of the mental health and substance misuse teams.
- Staff training and awareness discussions had taken place in relation to management of deep vein thrombosis (DVT) and clear guidance on identifying and managing patients with DVT had been circulated to all staff.