City Health Care Partnership CIC - HMP Hull

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.

Ratings

Overall summary

We carried out an announced focused inspection of healthcare services provided by City Health Care Partnership CIC (CHCP) at HMP Hull on 12 and 13 March 2019.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in April 2018, we found that the quality of healthcare provided by CHCP at this location required improvement. We issued Requirement Notices in relation to Regulation 9, Person centred care, and Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this focused inspection was to determine if the healthcare services provided by CHCP 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.

At this inspection we found:

- The mental health and substance misuse teams were working as an integrated team which enabled joint management of patients.
- New posts had been recruited to, and further recruitment was ongoing to increase the size of the team and broaden the base of skills and expertise available.
- Links were being made with community services to use their expertise within the prison.
- Mental health group sessions were now available and specialist pathways had been implemented to support patients with a learning disability and other neurological conditions.
- Care planning had improved and patients now had more detailed and person-centred care plans.
- Waiting times for the psychiatrist and dentist had reduced and were now being more effectively monitored, although there had been a recent increase in dental waits due to equipment failure.
- New audits had been implemented which had improved the monitoring of quality across most areas of the service.
- Responses to concerns and complaints were improved and those reviewed fully addressed the issues raised.

The areas where the provider **should** make improvements are:

- Take action to reduce the waiting times for routine dental appointments.
- Implement a detailed checklist for staff to use when checking emergency response bags.
- Improve recording of management supervision meetings.

Our inspection team

Our inspection team consisted of two CQC health and justice inspectors.

Before this inspection we reviewed a range of information that we held about the service such as action plans we had received from the provider as well as statutory notifications and other intelligence received.

During the inspection we asked the provider to share further information with us such as audits, patient care plans and information relating to staff recruitment and staffing structures. We spoke with healthcare staff, commissioners and sampled a range of records.

Background to City Health Care Partnership CIC - HMP Hull

HMP Hull is a local male adult Category B prison serving the East Yorkshire area. The prison is located in the city of Hull, England and accommodates more than 1000 adult prisoners. The prison is operated by Her Majesty's Prison and Probation Service.

CHCP is the health provider at HMP Hull. The provider is registered with the CQC to provide the following regulated activities at the location: Treatment of disease, disorder or injury, Diagnostic and screening procedures, Surgical procedures and Personal care.

Our last joint inspection with HMIP was in April 2018. The joint inspection report can be found at:

Are services safe?

We did not inspect the safe domain at this inspection.

Are services effective?

We did not inspect this key question in full during this focused inspection. We reviewed areas identified in the Requirement Notice issued to CHCP on 8 August 2018.

Effective needs assessment, care and treatment

At our last inspection, we found that:

- Effective support was not being provided to patients with a primary mental health need because of insufficient staffing levels.
- Mental health-related group sessions and clinical psychology was not available to patients.
- Patients with a secondary mental health need were not always seen frequently enough.
- Care plans were not in place for all patients with mental health needs.
- Where there was a care plan in place it did not contain the necessary detail to enable staff to provide appropriate care and treatment.
- There was no specialist pathway in place to support patients with a learning disability.

During this focused inspection, we found that the provider had improved the effectiveness of care provided for patients. We saw that the provider had ensured that the risks identified at the inspection in 2018 had been addressed. Actions taken included:

- The mental health and substance misuse teams were now integrated and working together as the 'Recovery Team'. This enabled more effective sharing of workloads and timely interventions. Recruitment was ongoing to expand the Recovery Team, some staff had already started and others were awaiting security clearance. New posts had been introduced to create a multi-disciplinary team, these included: mental health nurse, social worker, occupational therapist, learning disability nurse and a psychologist.
- The service provision had been increased to seven days per week so more one to one appointments could be offered at weekends.
- The range of primary and secondary care services available had increased which meant that staff were better able to meet patients' needs.
- Links were being made with community services to enable expertise to be shared with staff working at HMP Hull. This was also aimed at improving continuity of care for patients when they were released from the prison and their care had to be transferred to a community mental health team.
- Mental health groups were available with a clear process for patients to access them. Planning was underway to introduce more groups once newly recruited staff had completed their induction period.
- Substantial work had been carried out to implement and improve mental health care plans. Staff had clear guidance about the care and treatment patients needed and how frequently they should be seen. Care plans were being regularly reviewed with patients.
- Improved support was being provided to patients with a learning disability and further work was planned with the recruitment of a learning disability nurse. Work was also ongoing to implement specialist pathways to support patients with Attention Deficit Hyperactivity Disorder, dementia and other neurological conditions.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

We did not inspect this key question in full during this focused inspection. We reviewed areas identified in the Requirement Notice issued to CHCP on 8 August 2018.

Timely access to care and treatment

At our last inspection, we found that:

- The management of the psychiatrist's waiting list meant that patients were waiting too long to be seen.
- Patients were waiting too long for a routine dental appointment.

During this focused inspection, we found that the provider had improved the responsiveness of care provided for patients. We saw that the provider had ensured that the risks identified at the inspection in 2018 had been addressed. Actions taken included:

- The mental health clinical lead had developed their role and was now able to take some patients from the psychiatrist's waiting list.
- The psychiatrist had provided extra sessions as required which meant the waiting list was now minimal.
- There was better management and oversight of the psychiatrist's waiting list and any additions to it were monitored to ensure they were appropriate.
- Additional dental sessions had been provided which had reduced the wait for a routine dental appointment to approximately six weeks. However, some essential equipment had broken shortly before this inspection which meant the waiting times had begun to increase while a replacement was awaited. At the time of our inspection the wait for a routine appointment was approximately eight weeks. Dental staff had been proactive in arranging for a replacement to be fitted quickly. The provider told us they would provide additional sessions once the dental suite was fully functional to address any increase in waiting times.

Are services well-led?

We did not inspect this key question in full during this focused inspection. We reviewed areas identified in the Requirement Notice issued to CHCP on 8 August 2018.

Managing risks, issues and performance

At our last inspection, we found that:

- Checks of medicine in-possession risk assessments had not been carried out following a recent change to the process. This had led to a patient inappropriately being given their medicines in-possession.
- Checks were not carried out of the temperatures of rooms where medicines were stored.
- The checklist used for checking the contents of emergency response bags was not robust and did not identify what items should be in the bag.
- The responses to complaints were not checked prior to being sent to the patient. Some of the responses we saw had not addressed all issues raised by the patient and were abrupt.
- Where the provider was aware of issues with the quality of the service they had not always acted to address such issues.

During this focused inspection, we found that the provider had improved the governance and oversight of services provided at HMP Hull. We saw that the provider had ensured that most of the risks identified at the inspection in 2018 had been addressed. Actions taken included:

- Pharmacy staff carried out checks of the in-possession risk assessments for all new patients arriving the prison, following their completion by nursing staff during the initial reception screen. There was also a system in place to double check the in-possession risk assessments had been correctly completed when a patient's medicines in-possession status had been changed.
- Audit systems had been introduced to ensure that the temperatures of rooms where medicines were stored were checked daily. Staff reported any temperatures outside of the acceptable range to the pharmacy team for advice.
- Concerns and complaints were passed to the relevant senior member of staff to investigate and respond to. The administration team checked responses prior to them being sent to the patient. We reviewed a sample of recent responses and saw that they were timely, courteous and addressed all issues raised by the patient.

However, some issues remained that required further improvement:

- Whilst regular checks of emergency response bags were being carried out, the checklist still did not confirm what items should be in each bag. The provider acknowledged this issue and told us that this would be rectified following the inspection.
- Staff told us that they received regular supervision, in line with the provider's policy, and felt supported by their manager. However, records of supervision meetings were not always kept which meant it was not possible to evidence that supervision meetings had taken place. The provider was aware of this issue and was in the process of introducing new supervision paperwork. This was not fully embedded at the time of our inspection.