HMP Hewell

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.

Summary of this inspection

Detailed findings from this inspection

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 found that the trust was providing safe care in accordance with the relevant regulations

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Improvements had been made to the service since our last inspection, including strengthening pharmacy support and the skill-mix of the nursing team.

Are services effective?
We did not ask this question during this focussed inspection

Are services caring?
We did not ask this question during this focussed inspection

Are services responsive to people's needs?
We found that the trust was providing responsive care in accordance with the relevant regulations

- Patients we spoke with were positive about the service they received with the exception of access to prescribed medicines. The trust was taking action to address this.

Are services well-led?
We found that the trust was providing well-led care in accordance with the relevant regulations

- There was a clear leadership structure and staff felt supported by management.
- Whilst some aspects of service monitoring required further improvement, these had been identified by the trust. Actions were planned, or in progress, to ensure that improvements were made.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Through effective monitoring, optimise the use of available clinical time so that patients have timely access to assessment, care and treatment that meets their needs.
- In partnership with senior prison staff, review the arrangements for medicines administration to better manage patient confidentiality and the risk of misappropriation

HMP Hewell

Detailed findings

Background to HMP Hewell

HMP Hewell is a prison holding up to 1300 men across two main sites, including some held in open conditions. Worcestershire Health and Care NHS Trust provide a range of healthcare services to prisoners, comparable to those found in the wider community. This includes GP, dental, pharmacy and mental health services. The location is registered to provide the regulated activities of, diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury. We did not visit the 18 bed inpatient unit during this inspection. This inspection focussed on the areas of concern that had been raised with the Care Quality Commission.

Why we carried out this inspection

We undertook a focused inspection of HMP Hewell in partnership with Her Majesty's Inspectorate of Prisons in response to concerning information we had received about the safety and quality of the service. We inspected the provider against three of the five questions we ask about services: is the service safe; is it responsive to people's needs; is the service well-led? This is because we believed that there was a risk that the service was not meeting some legal requirements in these areas.

Are services safe?

Our findings

Learning and improvement from safety incidents

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses using the trust's electronic system. Incidents, including those relating to medicines, were reported and investigated effectively and we saw examples of improvements made in response to adverse events. Staff were encouraged to complete a reflective account of incidents and the learning from this was shared to reduce the risk of recurrence.

Medicines management

We looked in detail at the management of medicines, particularly in relation to their security. Staff worked in accordance with up to date policies and procedures and received good support from the developing pharmacy team. Stock was checked regularly. Incidents involving medicines were routinely discussed at the drugs and therapeutics and clinical governance committees. We observed the safe administration of medicines on two residential units but found that the risks to patients' confidentiality and the misappropriation of medicines were not well managed, due to the absence of adequate supervision by prison staff. The routine disposal of used medicine boxes was into a general waste bin at both hatches. This was in sight of prisoners and placed patients at risk of bullying or a breach of their confidentiality. We raised this with senior staff who took immediate action to address this risk.

Staffing and recruitment

We observed and analysed staffing levels within the primary care service and found that there was a limited number of GP sessions available, provided by 11 regular GPs. This meant that there was little flexibility to respond to unexpected GP absence. However, the trust had taken steps to address this through the deployment of an advanced nurse practitioner and prescribing nurses to support patients to receive the assessment and treatment they required. For example, the regular deployment of a prescribing nurse to the substance misuse clinic, ensuring that patients received prompt changes to their treatment. Vacancies within the administrative team were well managed to ensure that work was prioritised appropriately to support the clinical care that patients received. For example, requests to access patients' previous GP records were given a high priority to ensure that clinical decision-making was fully informed.

Recruitment of permanent GPs and nurses had been challenging, particularly since the commencement of the healthcare contract retendering process. A number of vacancies had been recruited to and those staff were awaiting clearance to commence work at the prison. Whilst many agency staff were routinely used, the majority had worked regularly at HMP Hewell and some had previously been permanent staff. This contributed to the continuity of care and treatment. However, there remained backlogs in some routine clinical assessments, such as physical health checks for patients prescribed treatment for their mental health. The manager was aware of this and was taking action to address it, including rationalisation of waiting lists.

Are services effective?

(for example, treatment is effective)

Our findings

We did not ask this question during this focussed inspection

Are services caring?

Our findings

We did not ask this question during this focussed inspection

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients we spoke with were positive about the service they received with the exception of their access to some prescribed medicines. Some patients told us that they experienced delays in receiving their regularly prescribed medicines following their arrival at the prison; however we did not find any evidence of unreasonable delays. Arrangements were in place to ensure that there was always a prescribing nurse or GP available during reception sessions and the trust held a comprehensive stock of frequently prescribed medicines.

Patients who held and managed their own prescribed medicines were encouraged to take responsibility by ordering their repeat prescriptions. However, we found that patients who received regularly prescribed medicines under nurse supervision frequently experienced delays in receiving them at the point where their prescription required repeating. This had been an ongoing problem, associated with the functionality of the electronic patient record system. However, plans were well advanced for an upgrade to this system during November 2015, to effectively improve the timeliness of repeat prescribing.

Access to the service

Patients had access to an appropriate range of primary care and other clinics, equivalent to those provided in the wider community. This included smoking cessation, physiotherapy and podiatry. GP appointments were available within two days and anyone with urgent needs was seen the same day. However, the management of clinic waiting lists meant that it was difficult for us, or the trust, to determine whether patients always received timely care. There were 57 waiting lists in place, some of which were specific to individual residential units, which was unwieldy. Care records did not always evidence why patients had been placed on waiting lists, or whether the need to be seen by a clinician had been met. Some work was in progress to improve mental health service delivery by rationalising waiting lists and creating nurse caseloads. Further rationalisation of other lists was planned.

Prompt action was taken when clinic delivery was impacted on by staff absence. For example, during our inspection a flu vaccination clinic had to be postponed; however, nurses visited a residential unit and offered flu vaccinations to patients. Some patients told us that they had been unaware of appointments that had been made for them and this had led to them not attending. Non-attendance at clinics was routinely monitored and some actions were planned to address this; such as the introduction of patient orderlies to deliver appointment slips. However, at 39%, the non-attendance rate for dental appointments was unacceptably high. The trust had explored the reasons for this but effective action had not been taken at the time of our inspection.

Patients had good access to external health appointments. These were well managed in partnership with the prison and cancellations for non-clinical reasons were infrequent.

Arrangements were in place to meet prisoners' social care needs. A separate provider had been commissioned to provide personal care and trust staff were working effectively in partnership where individuals also had health needs.

Listening and learning from concerns and complaints

The trust had a confidential system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance. We looked at the complaints received in the last 6 months and found that they were satisfactorily handled and responded to in a timely way, Complaints response times were monitored weekly by the practice manager. All relevant health staff had received training in complaints handling from experienced complaints officers. A random sample of responses to complainants were monitored each month for quality assurance purposes.

Are services well-led?

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

Our findings

Governance arrangements

The trust's corporate governance systems were operating effectively at a local level. Reporting to corporate committees was evident. Current policies, procedures and patient group directions were in place. Staff understood how to raise concerns or report incidents and they told us they felt able to do so. Incident investigation was robust.

Quality monitoring systems were effective, although some required refinement; such as the monitoring of clinics cancelled due to staff absence. Monitoring associated with medicines security and optimisation was robust in most areas, but needed to be further developed to ensure that patients' needs were met. For example, staff were unable to easily provide us with information about those patients who were prescribed five or more medicines, who may have required closer monitoring. High level prescribing audits had been introduced across three prisons; however, this data had not yet been disaggregated for local monitoring purposes.

Whilst we found some aspects of the service that required further improvement, these had largely been identified by the trust and actions were planned, or in progress, to ensure improvements were made. For example, the imminent upgrade of the electronic patient records system and the appointment of non-medical prescribers. Pharmacy support was being strengthened to reduce medicines management risks.

Leadership, openness and transparency

Partnerships with the prison were effective; the healthcare manager met monthly with the prison governor and provided a detailed report about the main risks to patient safety and service quality. This included service performance and developments and partnership issues such as the prescribing of medicines frequently misused within prisons. Regular operational meetings were attended by all relevant parties and were an opportunity to discuss issues, such as incidents and jointly seek solutions.

Management lead through learning and improvement

There was clear accountability within the staff team and we received positive feedback from staff about leadership and management. Staff were effectively supported and supervised and plans were in place to improve the supervision of GPs to be more equivalent to that provided in the wider community. Poor staff performance was proactively managed.