HMP Leeds

Inspection report

http://www.careukhealthcare.com/nhs-services/health-in-justice

Date of inspection visit: 13 December 2018
Date of publication: 26/03/2019

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 Care UK Health and Rehabilitation Services Ltd (Care UK) at HMP Leeds on 13 December 2018.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in November 2017, we found that the quality of healthcare provided by Care UK at this location did not meet regulations. We issued one 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 inspection was to determine if the healthcare services provided by Care UK 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 do not currently rate services provided in prisons.

At this focused inspection we found:

- The provider had made a range of improvements to the management of medicines, including CDs and repeat prescribing
- The provider had reviewed arrangements around repeat prescribing to improve continuity of treatment.
- There remained occasional delays in obtaining relevant patient information from community GPs.
- The provider had made improvements to the mental health service with prompt assessment and improved care planning for patients with mild to moderate mental health concerns.
- There was consistent support for men housed on the social care unit with mental health needs.
- There was variable support for patients with complex mental health needs and personality disorder which the provider began to address during the inspection.

The area where the provider **should** make improvements is:

- Ensure that all patients with complex mental health needs are consistently assessed and receive care and treatment supported by current risk assessments and care plans.

Our inspection team

This focused inspection was carried out by one CQC health and justice inspector, a CQC pharmacy specialist inspector and a CQC Specialist Professional Advisor.

Before this inspection we reviewed the action plan submitted by Care UK to demonstrate how they would achieve compliance. We also spoke with NHS England and Healthwatch prior to the inspection. Evidence we reviewed included:

- Operating procedures, policies and audits relating to for the use of medicines including administration of controlled drugs.
- Audits of patients' mental health records for August and November 2018.
- The logs of referrals into the mental health service and triage dates.
- Responses to patient satisfaction surveys for the mental health team.

During the inspection, we spoke with clinical managers, healthcare staff, mental health staff and pharmacy staff. We also reviewed patient clinical records around prescribing and mental health care.

Background to HMP Leeds

HMP Leeds is an adult male local prison, located in the Armley area of Leeds.

At the time of our inspection the population was around 1050 patients.

Health care services at HMP Leeds are commissioned by NHS England. The contract for the provision of healthcare services is held by Care UK Health and Rehabilitation Services Limited (Care UK). Care UK is registered with CQC to provide the regulated activities of Diagnostic and Screening procedures, Treatment of disease, disorder or injury and Personal care at HMP Leeds.

Our last joint inspection with HMIP was in November 2017. The joint inspection report can be found at:

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

Are services safe?

We did not inspect this key question in full during this focused inspection. We reviewed areas identified in the Requirement Notice issued to Care UK on 22 March 2018 and areas where we previously made further recommendations for improvements.

Appropriate and safe use of medicines

At our last inspection, we found that medicines were not being administered safely.

- There was no second checking of controlled drugs, including methadone, which was manually measured.
- Patients experienced delays in getting their repeat medicines.
- Buprenorphine, (a medicine to treat substance dependence administered in tablet form which is a high-risk medicine in a prison environment and can contribute to overdose) was being administered in a crushed form without appropriate protocols in place.
- Risk assessments for patients who were given medicines in possession were not appropriately reviewed.

During this inspection we found that the provider had taken the following actions to improve the safety of care provided for patients with substance use issues who were prescribed controlled drugs:

- Care UK recruited additional staff, training all healthcare staff to act as second checkers for the administration of controlled drugs.
- A machine for electronically measuring methadone (methadone is a liquid medicine for treating substance use which must be carefully measured and administered) had been ordered but was not yet in use.
- Staff understood the procedures for checking methadone measuring and administration.
- A protocol was in place for administering buprenorphine in crushed form to reduce risk to patients of diversion or potential overdose

The provider had made the following changes to the process of prescribing and ordering medicines to improve treatment safety and so that patients did not experience lengthy interruptions to their treatment:

- Pharmacy technicians reviewed patients' prescriptions regularly and requested repeat prescriptions from the GP.
- The provider monitored repeat prescribing by GPs but had not introduced an audit check of the clinical record system for further assurance.
- There were occasional delays of up to a week for patients who had been received from the community due to delays in community GPs confirming previous prescribing. This presented a risk to these patients. Managers were liaising with partners to improve patient safety to newly received prisoners.

Nurses and pharmacy technicians reviewed risk assessments for patients who were given their medicines in possession (in possession risk assessments are carried out by staff to reduce the risk of harm from medicines, particularly high-risk medicines in the prison environment).

- The provider was working with the prison management team to improve medicine storage arrangements to enable patients to safely keep their medicines in possession.

Are services effective?

We did not inspect the effective key question in full at this inspection. We inspected only areas identified in the Requirement Notice issued on 22 March 2018.

At our last inspection we found that there was poor assessment of, and care planning for, patients with mild to moderate mental health needs. Patients with mental health needs accommodated on the social care unit were not receiving effective care.

Effective needs assessment, care and treatment

During this inspection, we found that the provider had made improvements around needs assessment and care planning for patients with mild to moderate mental health needs. There was now a greater range of support for these patients.

- Mental health nurses assessed patients with mental health needs and agreed care plans with them.
- Staff offered a range of self-help material to support patients with mild mental health conditions including sleep hygiene and wellbeing.
- A suitably skilled mental health nurse provided psychological therapy. Group sessions were available, often facilitated jointly between substance misuse and mental health staff.
- The staffing profile now included a psychologist but there was no cover for their absence which meant this service was not available at the time of our inspection.
- The provider had recruited additional mental health nurses some of whom were awaiting clearance to commence work.

Managers had reduced the size of mental health nurses' caseloads which meant patients with mental health issues received greater continuity of care. However, we observed that some patients seeing the psychiatrist were not being appropriately supported by a mental health nurse.

- Not all patients with more complex mental health needs had appropriate care plans and risk assessments in place.
- Patients with complex mental health conditions were listed to see the psychiatrist but there was no care coordination for some of these patients.
- During the inspection, managers reviewed the support arrangements for patients with complex mental health conditions who were on the psychiatrist caseload. Several patients were allocated to mental health nurses to ensure their care was appropriately coordinated.

Monitoring care and treatment

The provider had implemented improved arrangements for monitoring care and treatment as well as reviewing medicines arrangements.

- Regular reviews of controlled drug registers and refrigerator monitoring ensured that all medicines were stored and administered in line with requirements, improving patient safety.
- The management team monitored the triage system to ensure that patients were seen in a timely way.
- The mental health manager conducted audits of care plans to ensure that patients' care needs were being met.
- There was limited evidence of shared learning from these audits which was a lost opportunity for further development.

The provider had improved oversight and joint working with prison staff for patients with social care needs. This ensured that patients with social care needs who also had mental health conditions received appropriate support from mental health nurses.

- Mental health staff regularly reviewed their patients located on the social care unit and liaised with partners where additional referral or support was required.

Managers monitored support for these patients through regular multi-disciplinary meetings.

Are services responsive to people's needs?

We did not inspect the responsive key question in full during this focused inspection. We inspected only areas identified in the Requirement Notice issued on 22 March 2018.

Timely Access to care and treatment

At our last inspection we found that patients referred to the mental health service were not being assessed in a timely manner.

During this inspection we found that the provider had made improvements to the referral and triage arrangements for patients with mental health needs and that their needs were being met more effectively.

The team had introduced a new triage system in September 2018 and monitoring showed that of 129 patients referred in October 2018, 108 were triaged within five working days and all of the 203 patients referred in November 2018 were triaged within five working days. This was a significant improvement and ensured patients received timely and appropriate care.

- The team ensured that most patients were reviewed and assessed in a timely way.
- Where primary care staff or the triage process identified a patient as requiring urgent mental health assessment, a mental health nurse carried out an assessment the same or the following day.
- Managers had reviewed the duties which mental health staff carried out which improved the number of staff available to carry out triage of referrals for mental health care.
- The triage process was regularly monitored and since October 2018, 96% of referrals had been reviewed within 5 working days.
- There was now appropriate care planning in place for patients with low to moderate mental health needs.
- Managers were working with prison management in develop more therapeutic space for mental health support on residential units also in order to improve access to care and support.