Pinewood House

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 rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Overall summary

We carried out an announced focused inspection of healthcare services provided by Oxleas NHS Foundation Trust at HMP & YOI Rochester on 11 July 2023.

Following our last joint inspection with HM Inspectorate of Prisons (HMIP) in September 2022, we found that the quality of healthcare provided by Oxleas NHS Foundation Trust at this location required improvement. We re-issued a Requirement Notice in relation to 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 were meeting the legal requirements of the Requirement Notice that we issued in November 2022 and to find out if patients were receiving safe care and treatment.

At this inspection we found the required improvements had been made in relation to Regulation 17, Good Governance. However, the provider was in breach of Regulation 16, Receiving and Acting on Complaints.

We do not currently rate services provided in prisons.

At this inspection we found:

- Systems and processes were not effective in monitoring and managing responses to complaints.
- Complaints were not always responded to in line with the provider's complaints policy.
- Quality of responses and investigations did not always reflect the nature of the complaint or indicate if it had been upheld or not.
- Staff had not received training in responding to complaints.
- Most complaints reviewed did not include an apology or clear information on how patients could escalate their concerns.

However;

- The number of complaints had reduced significantly.
- Managers maintained accurate records of staff training, including incident reporting and medicines management.
- Staff reported incidents and shared learning following incidents.
- Managers analysed data sufficiently and identified patient safety concerns, gaps in service provision and opportunities for service improvement.

Our inspection team

This inspection was carried out by two CQC health and justice inspectors.

Before this inspection we reviewed a range of information provided by the service including the requirement notice action plan, meeting minutes, policies and procedures and management information.

Background to Pinewood House

HMP & YOI Rochester is a category C training and resettlement prison for adult men and young offenders in Kent and accommodates up to 695 adult prisoners and young offenders. The prison is operated by His Majesty's Prison and Probation Service.

Oxleas NHS Foundation Trust is the health provider at HMP & YOI Rochester. The provider is registered with the CQC to provide the following regulated activities at the location: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

Our last focussed inspection of HMP & YOI Rochester was in September 2022. The inspection report can be found at: Urgent - RPGAB Bracton Centre Medium Secure Unit (24/10/2022) INS2-13930948846 (cqc.org.uk)

Inspected but not rated

Are services safe?

Staff Training

Staff received appropriate training and managers maintained accurate records of attendance.

At our last inspection staff had completed additional training in incident reporting and medicines management. However, we found that records of all those in attendance at the training sessions were not available and managers could not confirm who had completed this training.

At this inspection we found managers had developed a local system to maintain accurate records of staff training across the different teams. Managers updated this following completion of staff training.

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and routinely shared lessons learned with the whole team.

At our last inspection we found that staff had received training in how to report incidents and incident reporting had increased but remained inconsistent. We found several examples of incidents that staff had not reported. Managers investigated incidents; however, feedback to staff following investigation was poor and shared learning was limited.

At this inspection we found staff regularly reported incidents and shared learning following incidents had improved significantly.

Managers had received training in the investigation of incidents and at the time of this inspection, all incidents that required investigation were complete, there were no overdue investigations. Staff had opportunities to discuss incidents at the daily clinical handover. This meant staff could raise any concerns quickly and managers could respond promptly.

At our last inspection we found staff did not always report medicine related incidents, for example, when patients did not receive their medication for 3 consecutive days.

At this inspection we found staff reported medicine related incidents consistently. Analysis of the data showed that staff reported a range of issues relating to medicines and additional work had been completed with the pharmacy team to ensure that medicines were available for patients. This included a review of the in- possession medicines policy and process for requesting medicines. Most complaints received by Oxleas related to medicines; however, numbers were decreasing and the themes relating to medicines changed during each reporting period.

Incidents were discussed regularly by managers in the quality management meeting and with staff in team meetings. The quality and governance manager produced a monthly incident report, this provided an analysis of all incidents and was used in discussions at staff meetings. We reviewed minutes from these meetings and the quality of recording the minutes had improved significantly. Incidents reported by staff were discussed and outcomes from investigations actioned.

Oxleas had developed a system for sharing learning with staff. A quarterly newsletter was produced for the West Kent prisons, featuring details of incidents and learning across the prison cluster, including HMP & YOI Rochester. In addition, Oxleas had a RAG rated incident bulletin used to share learning. This approach enabled staff to quickly identify and prioritise learning, for example, red alerts are for immediate action, amber identifies key learning and green indicates outstanding practice. During this inspection we observed these bulletins on display in key areas.

Inspected but not rated

Are services safe?

At this inspection we found some examples of service improvements to patient care following incidents. For example, following an increase in incidents relating to controlled drugs, managers completed a desktop review of systems and processes. This enabled managers to identify where change was needed and improve processes and patient safety. In addition, staff across the West Kent prison cluster have participated in a quality improvement project focussing on medicines errors.

Improved recording in meeting minutes, shared learning and service improvements have helped to reduce repeated incidents and mitigate future risks.

Inspected but not rated

Are services responsive to people's needs?

Listening to and learning from concerns and complaints

Patients had access to a dedicated healthcare complaints system and a separate prison complaints process. The service did not always investigate and respond to complaints in line with the provider's policy; and the quality of some responses was poor.

At the previous inspection we found that staff did not upload complaints into the system daily. Complaint numbers were high, due to the repeated number of submissions created by an initial lack of response from the provider. There were delays with the prison sharing healthcare complaints they had received; this meant complaints were not logged or responded to within the expected timeframes.

Many complaints were not responded to and those that were, were poorly written and did not always address the nature of the complaint. There was minimal quality assurance of the complaints process.

At this inspection, we found that although some improvements had been made to the recording and oversight of complaints, further work was required to ensure patients received a satisfactory response in a timely manner. We reviewed a random sample of 14 complaints and the responses sent to patients. We found that the complaints were not responded to in line with the provider's policy and some were of poor quality.

Despite a monthly audit of complaints by the head of healthcare, not all responses to complaints were quality assured by the head of healthcare in line with the provider's policy. Not all staff responding to complaints had received the relevant training, which was a concern due to the number of poor-quality responses found during our inspection. For example, of the responses we reviewed, 6 were of a very poor quality with illegible handwriting and inadequate responses to the issues raised.

Duplicate spreadsheets were used to log queries and the data did not match on the two documents which could lead to errors in recording or missed responses to patients. Seven of the complaints we reviewed had a delay between the date the patient submitted the form, and the date healthcare received it. This ranged from 5 to 27 days delay and meant that patients did not receive a timely response to their complaint. Three complaints had not been responded to within the provider's 30-day timeframe.

Only 3 of the complaints reviewed were responded to in the form of a letter, offering an apology, outlining the investigation which had taken place and details of how the patient could escalate their complaint if they were not satisfied with the response.

However, at this inspection we found that managers had taken positive steps to engage with patients. This included attending the monthly prisoner forum, increasing visibility of managers across the different prison wings and completing patient satisfaction questionnaires. Healthcare prisoner representatives had also been recruited to bridge the gap between the healthcare provider and the prison population.

Inspected but not rated

Are services well-led?

Governance processes operated effectively at team level and were adequately used to identify issues relating to incidents and service improvements.

At this inspection, we found that most systems, processes and procedures had improved and helped managers to accurately assess, monitor and improve the safety and quality of the service. The service had an established framework of regular governance meetings such as the Kent prison cluster quality board, quality management meeting, clinical team leader and staff meetings. This ensured oversight of service performance and risks from both a provider and partner agency perspective. In addition, the flow of information between managers and staff was consistent, complemented by accurate records of all meetings.

Managers maintained accurate records of staff training and updated these regularly. However, most staff who responded to complaints had not received any training.

The service had an annual audit cycle to monitor the quality of the service provided. However, the monthly audit of complaints did not identify issues with the quality and timeliness of responses to complaints.

Successful recruitment into key posts, clearly defined roles and responsibilities for managers and patient engagement had enabled the service to progress. Staff were confident to report incidents, investigations were completed and learning shared. Improvements in systems and processes, data analysis and engagement with patients had contributed to a significant reduction in complaints about the service, although further work is necessary in relation to the quality and timeliness of responses.

Consistency in reporting incidents, reducing numbers of complaints and analysis of data has improved how managers identify patient safety concerns, gaps in service provision and opportunities for service improvement. Managers had developed a service improvement plan to reflect the needs of each team.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. In particular: • Not all staff responding to complaints had received the relevant training. • Not all responses to complaints were quality assured by the head of healthcare in line with the provider's policy. • Only 3 of the 14 complaints reviewed were responded to in the form of a letter, outlining the investigation which had taken place and details of how the patient could escalate their complaint if they were not satisfied with the response. • Of the responses we reviewed, 6 were of a very poor quality with illegible handwriting and inadequate responses to the issues raised. • Three complaints had not been responded to within the provider's 30-day timeframe. • Seven of the complaints we reviewed had a delay between the date the patient submitted the form, and the date healthcare received it. This ranged from 5 to 27 days delay and meant that patients did not receive a timely response to their complaint.