HMP YOI Stoke Heath

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 an announced desktop inspection of healthcare services provided by Shropshire Community Health NHS Trust at HMP YOI Stoke Heath in October 2019.

Following our last joint inspection with Her Majesty's Inspectorate of Prisoners (HMIP) in November 2018, we found that the quality of healthcare provided 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 the trust 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.

At this desktop inspection we found:

- The provision of emergency equipment had increased to support a prompt response to emergencies.
- The trust had worked with the prison and local authority to introduce new safeguarding protocols to support vulnerable prisoners.
- New pharmacy staff were in place and medicines were now managed safely.
- The mental health service was now fully integrated with a range of support available for patients with mild to moderate mental health needs.
- Patients who were referred to the mental health service were assessed within five working days.
- The trust had subcontracted a new dental service and additional weekly clinics had reduced waiting times to under 10 weeks.
- Several patients had been trained as Health and Wellbeing champions and actively supported the development of the health services at HMP YOI Stoke Heath.
- The healthcare team were proactive in working with partners to introduce new initiatives and improvements to support safe and effective patient care.

There were some areas where the trust should make further improvements.

- Review governance arrangements to ensure new processes are appropriately monitored and formally recorded to help inform continuous improvement.

Our inspection team

This inspection was carried out by one CQC health and justice inspector, one CQC pharmacist specialist and one CQC inspection manager. We did not visit the prison to carry out this inspection because we were able to gain sufficient assurance through the documentary evidence provided and a telephone conference with relevant managers.

We reviewed the action plan submitted by Shropshire Community Health NHS Trust to demonstrate how they would achieve compliance. The trust also submitted a wide range of documents to demonstrate improvements in the care provided at HMP YOI Stoke Heath since the last inspection. Evidence we reviewed included:

- Arrangements for the provision and checking of emergency bags
- New policies on incident reporting and safeguarding
- Minutes of meetings with the prison and Local Authority on safeguarding and training arrangements for staff
- Minutes of multi professional meetings demonstrating actions taken
- Copies of stock checks and medicines governance meeting minutes
- New operating procedures for the administration of medicines in the segregation unit
- Daily record sheets for room and refrigerator temperature monitoring
- The new complaints process and evidence of monitoring
- The new pain management pathway
- Details of the new mental health provision and staffing
- Details of patient caseloads and access to the mental health team
- Current waiting lists and times to see the dentist
- A statement from the governor of HMP YOI Stoke Heath about partnership working with the trust prison healthcare team.

We also reviewed recent performance information from NHS England commissioners responsible for the service.

Background to HMP YOI Stoke Heath

HMP YOI Stoke Heath is a closed category C adult male and young adult training prison. The prison is in a rural part of Shropshire and holds prisoners from the West Midlands, Wales and North West England. The prison also accepts prisoners from three part-time Welsh courts.

Health services at HMP YOI Stoke Heath are commissioned by NHS England. The contract for the provision of healthcare services is held by Shropshire Community Health NHS Trust. The trust provided some aspects of healthcare services at the time of the last inspection in November 2018, however, it commenced a new contract on 1 April 2019 as prime provider for healthcare services. The trust is registered with CQC to provide the regulated activities of Diagnostic and screening procedures, and Treatment of disease, disorder or injury.

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

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-yoi-stoke-heath/

This report covers our finding in relation to those aspects detailed in the Requirement Notices issued to Shropshire Community Health NHS Trust in March 2019 and areas where we made recommendations for improvement at the last inspection. We do not currently rate services provided in prisons.

Are services safe?

We did not inspect this key question in full during this focused follow up inspection. We reviewed areas identified in the Requirement Notice issued to the trust on 19 March 2019 and areas where we made further recommendations for improvements.

At our last inspection in November 2018 we found that the provider had not done all that was reasonably practicable to mitigate risks to the health and safety of patients. Issues we noted included:

- There was one emergency bag for an expansive prison site, which could lead to delays in responding to incidents.
- A significant injury to a patient had not been reported
- Medicines were not managed safely, this included inadequate stock management and auditing arrangements, unsafe administration of medicines to patients in the segregation unit and poor temperature monitoring of refrigerators to ensure that medicines stored in refrigerators were safe and effective for use. We were also concerned that where patients required sedative medicines they were given too early.

Safety systems and processes

During this inspection we noted that:

The trust had provided two additional emergency bags and submitted bids to NHS England commissioners for additional emergency equipment. In total there were 10 emergency bags in place, with one being located on each residential unit. This meant nurses did not have to carry heavy emergency bags over long distances and reduced the time to respond to emergency incidents. There were regular checks of the emergency equipment.

The trust had worked with prison staff to conduct a review of joint safeguarding arrangements and policies. They had also built upon existing trust relationships with the local authority to develop a partnership approach for prison safeguarding issues. There had been ongoing awareness raising with healthcare staff over incidents which they should be reporting. Effective partnership working had led to a greater awareness around protecting vulnerable people throughout the prison. The trust provided a range of evidence where concerns over a patient's wellbeing had been escalated and nurses were clearly identifying and reporting potential safeguarding incidents. Further work remained under way to introduce a suitable prison specific safeguarding training package. We saw examples around safeguarding reporting and support to demonstrate that the new safeguarding processes were now equivalent to that in the community which was a significant achievement for a prison site.

Appropriate and safe use of medicines

The trust had recruited additional pharmacy staff which meant that healthcare staff were better supported by a qualified pharmacist and two part time pharmacy technicians around medicines management.

A new process for stock checks was implemented in May 2019 and had been reviewed. This meant that medicines expiry dates were monitored with new stock ordered in sufficient time and out of date stock disposed of promptly.

An interim process for the administration of medicines in the segregation unit was implemented immediately after the last inspection to ensure safe administration of medicines. In April 2019 a new operating procedure was implemented, using a portable medicine trolley. The trolley was secured within the segregation unit when it was not in use. The trust escalated any concerns from prison staff over medicines administration at daily meetings and managers completed observations of new staff to ensure that the new process was being followed. There was no routine audit of segregation administration processes.

All nurses now printed off prescriptions prior to attending the segregation unit and only administered medicines to one patient at a time. They returned promptly to the healthcare centre to enter all administration information into the electronic patient record system.

There were ongoing discussions with prison managers about how to facilitate access to the electronic patient record system in the segregation unit.

A new refrigerator had been purchased for vaccine storage and the refrigerator temperature monitoring arrangements were reviewed. Staff now completed daily records which were reviewed by the pharmacy team. When temperatures were out of range staff reported this and appropriate action was taken to ensure medicines remained safe and effective.

Are services responsive to people's needs?

We did not inspect this key question in full during this focused follow up inspection. We reviewed areas identified in the Requirement Notice issued to the trust on 19 March 2019 and areas where we made further recommendations for improvements.

At our last inspection in November 2018 we found that the service was not always responsive to the needs of patients.

- Responses to complaints varied in quality, there was limited face to face resolution and no details were given to patients to advise how they could take a complaint further if they were not satisfied with responses.
- There was no effective pain management pathway in place and patients were frustrated with access to pain relief medicines.
- Mental health service provision did not meet the needs of all patients. Patients referred into the mental health service were waiting too long for assessments and there was insufficient support for patients with complex personality disorders, and those with mild to moderate mental health needs.
- The dental service was insufficient to meet the demand with waiting times of around 18 weeks for routine appointments.

Responding to and meeting people's needs

A pain management pathway had been introduced in April 2019 with the implementation of multi-disciplinary reviews for patients with complex pain needs. Meetings had taken place to support GPs with prescribing of pain medicines. A new GP contract had commenced on 1 September 2019 and there was a multi-disciplinary approach to pain management through a weekly meeting. Patients with complex pain were reviewed by GPs and there was liaison with physiotherapists and substance misuse staff around assessment and treatment to help patients reduce their reliance on pain medicines where there was a risk they could contribute to overdose or other risks. There was effective communication with patients around the risks of pain relief and the reasons for reduction.

The integrated arrangements to support patients with mental health needs had improved. The current contractual arrangements had led to increased staffing levels within both teams and a greater range of therapeutic support for patients was available. The primary mental health team, the sub-contracted secondary mental health team and the substance misuse team were now co-located and fully integrated which offered a more holistic experience for patients. Multi-disciplinary meetings demonstrated more effective shared care where prisoners had complex needs or personality disorders.

The range of therapeutic support had significantly increased and now included cognitive behavioural therapy, mindfulness, various groups and relaxation events as well as improved peer support arrangements for patients with mild to moderate mental health needs.

Timely access to care and treatment

Patients referred into the mental health team were now assessed within five working days or sooner if there were concerns about their wellbeing.

A new dental contract had been introduced and weekly clinical sessions had increased from four to an average of six sessions. Managers reviewed the demands on the dental service monthly and had worked with dental staff and NHS England to ensure the provision met the demand. Waiting times had been reduced from 18 weeks to around 10 weeks for routine care. Managers were currently monitoring ongoing treatment courses to ensure that enough appointments for new patients remained available. Patients with pain or urgent dental needs were seen within three days.

Listening and learning from concerns and complaints

A new complaints process was introduced in April 2019 as part of the new contractual arrangements.

Early analysis had showed a high number of complaints around prescribing for pain relief and this had contributed to the development of the pain management pathway.

Information about complaints trends and action taken was shared throughout the prison with "you said … we did" posters and information.

There had been 152 complaints submitted in between April and September 2019. The trust patient advice and liaison service (PALS) team supported the Stoke Heath healthcare team with the complaint management process. The Head of Healthcare held weekly complaint clinics and patients were invited to meet with her to discuss their concerns. Between April and September 2019 they ahd met with 28 patients. Written responses now included relevant

Are services responsive to people's needs?

information on how a patient could escalate their concern if they were not satisfied with the response. Complaints trends were now used to monitor the service, and a range of information was shared with patients.

The PALS team completed an annual review of all Shropshire Community Healthcare NHS Trust complaints for 2018/19 which identified trust-wide trends and data. However, there had been no quality assurance review of responses at HMP YOI Stoke Heath. The trust was aware further work was required to develop a quality assurance overview of local complaints processes.

Are services well-led?

We did not inspect this key question in full during this focused follow up inspection. However, during this inspection, we saw evidence to show how the provider had continually improved the service and have reported on the elements which demonstrate continued improvement.

Leadership capacity and capability

Since our last inspection, the trust had recruited a permanent head of healthcare who complemented the clinical lead nurse and team leaders. Planning for the changed contractual arrangements had included trust staff who had been instrumental in developing the service to meet the needs of patients.

The prison governor reported that since the new contract was implemented, healthcare partnership working was more integrated and healthcare staff were more visible at prison meetings.

The trust supported the prison healthcare team with regular senior leader support visits and the range of wider governance and support services. An example of current support was the planned introduction of a pop-up Schwartz round within the prison, to help enable prison healthcare staff to participate in this reflective practice forum.

Engagement with patients, the public, staff and external partners

The evidence we reviewed demonstrated highly effective engagement with patients, staff and partners. This included:

The full implementation of the Health and Wellbeing Champions (HAWCs), these were prisoners who had completed a public health accredited course in health and wellbeing. There were appropriate governance and support arrangements in place for these prisoners who worked closely with the healthcare team. HAWCs acted as patient representatives, and they provided peer support for prisoners at all stages of their prison journey from reception through to release. The HAWCs offered buddy support for vulnerable patients and were currently working with the learning disability nurse to improve identification of prisoners with learning difficulties who might benefit from additional support. We reviewed feedback from one HAWC as part of the inspection who explained the impact the role had had on his own life and rehabilitation, but also how rewarding the role was in building a legacy of recovery, support and health and wellbeing.

Through the subcontracted substance misuse provision, there was also work in progress to improve release and resettlement opportunities for prisoners. Relationships had been developed with a number of voluntary sector partners, with hopes that volunteering and employment opportunities might be available for prisoners, particularly those who were accredited as HAWCs on release in the future.

Continuous improvement and innovation

The development of the HAWC model had been based on learning from other prisons. However, at Stoke Heath, this had been taken further. A HAWC representative now attended the start of weekly multi-disciplinary meetings to share their concerns about individual patients. During this meeting they engaged with all clinical specialists including psychiatrists. The trust reported that feedback from HAWCs, prisoners and clinicians was positive, with the sense that there was a much more holistic understanding of vulnerable patients and their needs.

Healthcare managers were in discussion with NHS England commissioners and prison management around the possible implementation of mobile technology to support more flexible healthcare working and access to patient clinical records. There were also discussions taking place as to whether the use of a tele-medicine service could improve access to secondary care and reduce external escorts.

Prison healthcare managers had liaised with a national charitable organisation to run a new music initiative from January 2020. This was to be evaluated by the University of Cambridge.