HMP Hewell

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 focused inspection of healthcare services provided by Care UK Health and Rehabilitation Services Limited (Care UK) at HMP Hewell on 4 February 2020. We last inspected the service in June 2019 when we judged that Care UK was in breach of CQC regulations. We issued three Requirement Notices on 25 September 2019 in relation to Regulation 12, Safe care and treatment, Regulation 17, Good governance and Regulation 18, Staffing, 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. We found that improvements had been made and the provider was no longer in breach of the regulations.

We do not currently rate services provided in prisons.

At this inspection we found:

- There was increased staffing in healthcare, particularly within the clinical substance misuse and pharmacy teams, which led to improved outcomes for patients.
- Ongoing partnership working with the prison was improving attendance at healthcare by reducing missed appointments.
- The provider had introduced systems to help ensure patients arriving at HMP Hewell with substance dependencies were appropriately identified and monitored.
- The provider ensured an appropriate check of community prescribing records took place for patients arriving from courts to ensure patients received continuity of care with medicines.
- Regular supervision helped support staff.
- Healthcare staff worked with prison managers to relocate the substance misuse and mental health staff into a single location. This improved staff safety and patient continuity of care.

The areas where the provider should make improvements are:

- Fully embed new processes for safe storage and management of medicines.
- Monitor and assess patients with substance misuse needs in line with guidance and report and escalate any omissions.

Our inspection team

The inspection was conducted by two CQC health and justice inspectors, one CQC pharmacist specialist and one CQC specialist professional advisor.

Before this inspection we reviewed the action plan submitted by Care UK to demonstrate how they would achieve compliance, along with a range of other documents submitted by Care UK, to evidence how they would achieve compliance.

Evidence we reviewed included:

- Monitoring data for patients supported by the clinical substance misuse team
- Supervision monitoring log
- Medicines management data and monitoring information
- Service performance data
- A sample of eight patient clinical records

During the inspection we spoke with the head of healthcare, pharmacy staff and clinical substance misuse staff.

Background to HMP Hewell

HMP Hewell is a closed category B adult male local prison, located in a rural part of Worcestershire. There was also a small category D open prison unit, Hewell Grange, currently holding only 50 men, though this was scheduled to close in March 2020. Until January 2020 the prison had been receiving prisoners from courts in the West Midlands, which had increased the turnover of remand and newly sentenced prisoners. During our visit HMP Hewell was holding 900 male prisoners.

Health services at HMP Hewell are commissioned by NHS England. Care UK is contracted by NHS England to provide healthcare services. Care UK is registered with CQC to provide the regulated activities of Diagnostic and screening procedures, and Treatment of disease, disorder or injury at this location.

The report on the June 2019 comprehensive inspection can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-hewell-3/

This inspection report covers our findings in relation to those aspects detailed in the Requirement Notices issued to Care UK in September 2019.

Are services safe?

We did not inspect this key question in full at this inspection. We inspected aspects mentioned in the Requirement Notices issued to Care UK in September 2019 and areas where we made further recommendations for improvements.

At our last inspection we found that there were areas of care and treatment which required improvement. These included:

- Arrangements were not in place to fully assess and monitor the risks to patients requiring alcohol detoxification.
- Patients who arrived at HMP Hewell with substance dependency were not monitored in line with clinical guidance.
- Patients arriving at HMP Hewell who required critical medicines did not consistently receive these without delay.
- Learning from patient deaths had not led to sufficient action to help prevent future deaths, in particular medicines reconciliation checks were not consistently undertaken for patients arriving at the prison.

Risks to patients

- Urgent changes were made by staff immediately following our 2019 inspection, to identify patients who presented with significant alcohol dependency and who might be at risk of severe alcohol withdrawal symptoms. This required effective partnership with prison managers to ensure these patients were located in cells with larger observation panels.
- Staff now consistently identified patients who required overnight observation and escalated this to prison managers if they were not located in the correct cells. Prison managers were informed they needed to monitor these patients, if they were located where healthcare staff were unable to do so. Instances where patients were not appropriately located were reported through the incident reporting system and escalated to healthcare managers and the prison governor.
- Healthcare managers and commissioners had highlighted the risks patients with significant substance dependencies and potential withdrawal were exposed to, with local and regional prison managers. This enhanced shared scrutiny and oversight of this risk led to improved patient outcomes.
- New systems had been introduced to help ensure patients being treated for opiate dependency were monitored in line with national guidance. Healthcare support workers had been trained to support the clinical substance misuse team with daily observations and monitoring to identify opiate withdrawal symptoms. In June 2019 patients being treated for substance misuse did not receive regular clinical observations, some were seen only once in their first five days at HMP Hewell. There was now clear accountability to help ensure patients were monitored daily. Occasions when this did not happen were reported to managers.
- Substance misuse staff were using national screening tools to monitor patients with alcohol and opiate dependency. This included, the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar) and the clinical opiate withdrawal scale (COWS). Patient records demonstrated these scales were used consistently. However, there were occasions where the incorrect screening tool was used. Managers had identified this, taken appropriate action, and learning was shared with staff.

Appropriate and safe use of medicines

The provider had recruited and trained additional pharmacy technicians and introduced new systems to improve medicines safety since our 2019 inspection. This included:

- Prompt identification of newly arrived patients who may have complex health needs or have been prescribed potentially critical medicines in the community (critical medicines were those where missing an individual or few doses will lead to adverse outcomes for patients).
- Prioritising newly arrived patients with complex health needs or who had been prescribed critical medicines in the community for medicines reconciliation reviews and prescribing to ensure continuity of care. The percentage of patients whose medicines were reviewed within 72 hours of arrival at the prison increased from 5% in June 2019 to 82% in December 2019.
- A range of local operating procedures to ensure medicines were managed safely were now in place and signed by pharmacy staff and nurses.
- The pharmacy team had reviewed medicines in emergency bags and ensured that use by dates for glucagon (a medicine used for diabetic patients with low blood sugar) reflected storage at ambient temperatures.

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- Nurses had now signed patient group directions (PGDs, these allow nurses to supply and/ or administer a list of identified medicines) and these were authorised by managers. However, pharmacy technicians were currently administering some over the counter medicines in line with a homely remedy policy following different processes, which was not recorded in individual medicines administration records. This meant that patients might be able to request additional pain relief from nurses who would not easily see that paracetamol had already been issued.
- The administration of medicines in the segregation unit had changed during our last inspection and this safe process was now fully embedded. Discussions continued between healthcare and prison managers to further improve medicines administration in the segregation unit.
- Not all medicines were stored securely. Healthcare staff were reliant on, and working with prison facilities contractors to address this risk.
- Medicines management meetings had now been embedded and a range of medicines use monitoring took place to help keep patients safe.
- There was no system in place to carry out spot checks on patients who had their medicines in possession. This required further work with prison staff to help ensure that abuse, misuse or diversion of these was actively monitored and prevented to keep patients safe.

Lessons learned and improvements made

Staff had reviewed and disseminated the learning from significant incidents and deaths in prison custody to ensure that all learning had been embedded. All areas for improvement were recorded in the datix incident management system and these were reviewed at governance meetings.

Staff from the substance misuse team had been supported to report concerns around access to patients and location of patients requiring overnight monitoring. The increase in reporting of incidents, supported healthcare managers in working with prison managers to improve patient safety.

Substance misuse managers had introduced a daily multi-disciplinary team meeting to discuss patients on the substance misuse team caseloads. This ensured there was relevant psychosocial input into prescribing reviews and that all patients with substance misuse were referred for psychosocial support. Improved integrated working between clinical and psycho-social staff was improving patient safety and outcomes.

Are services effective?

We did not inspect this key question in full at this inspection. We inspected aspects mentioned in the Requirement Notices issued to Care UK in September 2019 and areas where we made further recommendations for improvements.

At our last inspection we found there were areas of care and treatment which required improvement. Patients with substance misuse needs were not effectively monitored and records were not maintained of staff trained and authorised to administer medicines without prescriptions. Staff supervision was not embedded and many staff, including new staff did not receive appropriate support.

Effective needs assessment, care and treatment

The increased focus on ensuring patients with substance misuse needs had led to improved outcomes for patients.

- There had been improvement in joint working with prison staff to help ensure patients who arrived and were prescribed clinical substance misuse medicines received their first doses the same day. Patients were now escorted directly from reception to the healthcare unit, which meant there were no delays in treatment. In December 2019, all patients prescribed substitute medicines received these medicines on the same day.
- The numbers of patients monitored daily by the substance misuse team had increased from 76 in July 2019 to 343 in December 2019.
- Between April and June 2019, some patients waited five days for a clinical substance misuse assessment. Between October and December 2019 no patient waited more than one day for assessment.
- During June 2019, 81 patients with substance misuse needs were not located in the substance misuse unit to support effective monitoring. In December 2019, this had reduced to 16 patients identified with substance misuse needs who were not located in the substance misuse unit. This meant there was more effective monitoring of patients who required it.
- Integrated working between the clinical and psychosocial substance misuse and mental health teams had increased with a focus on individualised patient care.
- The numbers of patients receiving clinical reviews in line with guidance had also increased significantly since June 2019. This gave assurance that patients who required medicines to treat substance dependency were appropriately reviewed.
- Healthcare managers and staff had worked actively with prison managers and staff to improve attendance at healthcare appointments. Non-attendance rates had decreased since our inspection in June 2019. Between April and June 2019, non-attendance at GP appointments had ranged from 13% to 27%. Between October and December 2019 this had reduced to between 3% and 11%. There had been similar increased attendance at nurse, podiatry, dental and psychiatry appointments. Managers informed us work continued in this area, which demonstrated the ongoing focus on ensuring healthcare was prioritised within the prison.

Monitoring care and treatment

A range of management checks had been introduced since the last inspection to help ensure patient care was effective and met requirements. These included:

- Daily and weekly management oversight of clinical observations being undertaken for patients with substance misuse needs.
- Monthly oversight of patients placed on opiate substitute treatment to ensure they received their medicines in a timely way.
- Pharmacy oversight and monthly monitoring of medicines reconciliation checks for patients who had arrived from the community.
- Improved monitoring of partnership working with social care providers to ensure that patients with social care needs were monitored appropriately by healthcare and prison managers.
- Routine oversight of prescribing of high risk and addictive medicines by the pharmacist. This was monitored at medicines management meetings. Pharmacists and GPs were highlighting where therapeutic doses were questionable. However, quality audits of the impact of medicines on patient outcomes had not yet been developed.
- Monitoring of completion of medicines in-possession risk assessments (IPRA, these review risks of a patients holding their medicines in possession themselves and inform prescribing decisions) demonstrated there had been an increase to 98% in September 2019 which was the highest achievement for two years.

Effective staffing

Managers had prioritised increasing staffing in the clinical substance misuse team since the concerns we identified at

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the inspection in June 2019. New staff had been appointed to increase staffing, and further recruitment was underway. Current clinical substance misuse team staffing included clear leadership and a range of staff, some of whom were being supported to develop their clinical skills. There remained some staffing pressures which managers were addressing and any shortfalls were being monitored.

There was continued oversight and performance management of clinical substance misuse staff to ensure they were following guidance correctly.

There had been some increased in staffing in the wider primary care and pharmacy teams with consistent agency nurses covering some of the remaining vacancies. New starters included a clinical manager, three health care assistants, one paramedic and four pharmacy technicians.

- A recruitment day had been planned for December 2019, this had been postponed following the media attention surrounding the closure of Hewell Grange.
- Managers had now embedded appropriate supervision arrangements with a mixture of managerial, clinical and group supervision which was recorded and monitored.
- Staff received alternate monthly clinical or managerial supervision . Detailed of topics covered were recorded in the monitoring spreadsheet.
- A range of additional training sessions had been facilitated to support staff development and increase staff competence. These included tuberculosis identification and care, infection prevention and control and asthma care.

Are services well-led?

We did not inspect this key question in full at this inspection. We inspected aspects mentioned in the Requirement Notices issued to Care UK in September 2019 and areas where we made further recommendations for improvements. During this inspection we saw evidence to show how the provider had continually improved the service and have reported on the elements which demonstrate this.

At our last inspection we found there were areas of care and treatment which required improvement.

Systems and processes to assess and monitor the quality and safety of the service had not identified all potential risks to patients, particularly around patients with substance misuse needs and learning from patient deaths.

Leadership capacity and capability

Health care managers had increased their monitoring of the service and partnership working with the prison. Improved patient care demonstrated that management had the capacity and capability to lead the service.

Governance arrangements

Additional governance and monitoring had been implemented since our last inspection. This included daily, weekly and monthly oversight of clinical substance treatment, medicines reconciliation and staff supervision. There was also oversight by the regional substance misuse lead and the regional prison drug strategy team.

Managing risks, issues and performance

The provider maintained a risk register which identified current risks to the service. Risks were appropriately prioritised and acted upon to improve patient care. Staff recruitment remained a risk under continual review.

Engagement with patients, the public, staff and external partners

Staff were positive about the improvements to support and supervision. Staff described changes since the last inspection and were aware of and involved in planning new ways of working. Staff confirmed joint working with prison officers was improving and they felt more supported by prison staff now than at the time of our last inspection.

Healthcare managers had worked continuously with prison managers to improve patient care and staff wellbeing. A significant improvement was the move of all substance misuse and mental health staff to a new office, facilitating improved integrated working and continuity of care for patients.

Continued working with prison managers and NHS England commissioners was improving patients' access to healthcare, and non-attendance rates had reduced over the previous nine months.

A range of options for increasing clinical and pharmacy facilities had been discussed with prison and NHS England commissioners at local delivery board meetings. Plans had been submitted for changes and funding. There were plans in place to introduce 10 drug support cells on a drug recovery unit, and to provide one constant observation cell in the inpatient unit.

Continuous improvement and innovation

The team was working closely with prison managers, NHS England commissioners and health partners to plan for the prison transition to a remand only prison in April 2020. Managers were working with staff to plan a new model of care, which would increase focus on newly arrived prisoners through an "early days" team. Plans also included an urgent health response team and a long term and complex care team to ensure the needs of all patients were met.

The team was currently trialling the implementation of the Care UK national clinical substance misuse policy and had identified differences between this and the local processes introduced in June 2019. Managers were working closely with regional and national leads to ensure the Care UK policy both reflected national guidance and could be consistently applied in the prison environment.

One prison residential wing had been identified to become a recovery wing and health care staff were working with prison officers to improve joint working and help ensure clinical care and observations were prioritised.