Spectrum Community Health C.I.C.

One Navigation Walk

Inspection report

1 Navigation Walk
Hebble Wharf
Wakefield
West Yorkshire
WF1 5RH
Tel: 01924 311400
Website: https://spectrumhealth.org.uk/

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Overall summary

This inspection was an announced focused inspection carried out on 5 July 2018 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection between 10 and 13 July 2017.

The July 2017 comprehensive inspection was carried out in partnership with Her Majesty's Inspectorate of Prisons (HMIP) under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions in accordance with our published methodology. CQC issued one Requirement Notice under Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to Spectrum Community Health C.I.C. This can be found in Appendix 2 of the joint inspection report. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp.../Holme-House-Web-2017.pdf

This focused inspection report covers our findings in relation to those aspects detailed in the Requirement Notice dated 5 December 2017 and findings published in the joint report. We do not currently rate services provided in prisons.

Our key findings at this focused inspection were as follows:

- The GPs gave information or reasons to patients when changes of medication were made, either in person or by letter.
- Complaints about medicines had significantly reduced since our last inspection.
- Where prisoners were issued medicines in possession, there was variable recording of appropriate assessment of the risks in patient records.

The area where the provider should make further improvements is:

In possession risk assessments should be updated where the prescriber feels the need to stop prescribing high risk tradable medicines. All prescribers should ensure they refer to recent changes when prescribing medicines in possession. Clinical records should clearly document reasons why high-risk medicines are prescribed in possession where there has been recent non-compliance or diversion of these medicines.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
We did not inspect the safe key question in full during this inspection. We inspected one area which had been identified as a risk at other prisons, the management of risks of patients holding their medicines in possession by prescribers. We found that although there were clear risk assessments in all patient records, these were not always updated by prescribers when there were changes in circumstances.

Is the service effective?
We did not inspect this key question during this focused follow up inspection.

Is the service caring?
We did not inspect this key question during this focused follow up inspection.

Is the service responsive?
We did not inspect this key question in full at this inspection. We inspected only the area identified in the Requirement Notice, dated 5 December 2017

We found that the areas of concern had been addressed. Patients were either given information about changes to their prescribed medicines in person or they were given a letter which contained all relevant information about the changes.

Is the service well-led?
We did not inspect this key question during this focused follow up inspection.

One Navigation Walk

Detailed findings

Background to this inspection

One Navigation Walk is the registered location for a range of community and prison health services provided by Spectrum Community Health C.I.C. (Spectrum). This includes the provision of GP and pharmacy services into HMP Holme House.

HMP Holme House is a purpose-built category B prison which was designated as a reform prison in 2016. During our visit HMP Holme House was holding around 1,200 male prisoners.

Health services at HMP Holme House are commissioned by NHS England. The contract for the provision of GP and pharmacy services is held by Spectrum. This report covers our findings in relation to those aspects detailed in the Requirement Notice issued to Spectrum in December 2017. We do not currently rate services provided in prisons.

CQC inspected this location with HMI Prisons between the 10 and 13 July 2017. We found evidence that fundamental standards were not being met and one Requirement Notice was issued to Spectrum for Regulation 9, Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked the provider to make improvements regarding this breach. We checked this area as part of this focused inspection and found that the provider had addressed the issues identified that fell within their control and remit.

How we carried out this inspection

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

During this inspection we reviewed the action plan submitted by Spectrum to demonstrate how they would achieve compliance. Evidence we reviewed included:

- A report generated from the electronic patient clinical record system on letters written to patients
- Medicines in possession risk assessment audits
- Complaints analysis
- Patient clinical records
- Waiting lists for GP appointments

We spoke with clinical managers, healthcare staff, the lead GP, the GP who supported patients with substance misuse treatment and the prison governor.

Is the service safe?

Our findings

We did not inspect this key question in full during this focused follow up inspection. However, we did review risks associated with medicines prescribing as this had been a risk at other prison sites where Spectrum provided GP services.

Safe and appropriate use of medicines.

During this focused inspection we reviewed the provider's policy and practice around assessing risks in relation to the prescribing medicines for prisoners to keep in their possession. In particular, we were reviewing safety around a range of high risk tradable medicines. These are medicines which are used for pain relief but can have significant side effects. They are desirable because of their euphoric and sedative effects, can be addictive and have a high risk of overdose, including death, especially where combined with other prescribed and non-prescribed substances. HMP Holme House had been experiencing significant issues with the availability of illicit substances over the 18 months prior to our inspection. Recent security changes had reduced the availability of illicit substances at HMP Holme House, and therefore the demand for prescribed medicines remained high with pressure on vulnerable prisoners to sell or trade legitimately prescribed medicine.

For all prisoners who had arrived at HMP Holme House in the eight months prior to our inspection, medicines in possession risk assessments had been completed in the new national screening template. GPs and prescribers had access to the information in this risk assessment when prescribing medicines.

GPs were clearly aware of the risks of high risk medicines, and a close working arrangement between health providers and prison staff was intended to mitigate against these risks. Where prisoners were prescribed tradable medicines in possession, the GP requested regular spot checks. If staff found discrepancies during these checks, this led to a review of the high-risk medicines by the GP. There was also careful observation by nursing staff at medicines administration times, where suspected diversion of medicines led to a review of CCTV footage and potential review of prescribing by the GP.

Despite prompt changes to prescribed medicines where there was non-compliance, the GP did not automatically review medicines in possession risk assessments when changes were made. GPs did not always document clinical reasoning for prescribing decisions.

For example, we noted two occasions in the previous six months where the regular GP had stopped the prescribing of high risk medicines due to evidence of trading or failing to present the correct numbers of tablets during a spot check. In each case the GP wrote to the patient with an explanation, including information on the risks of overdose and offered a review. The GP did not make any changes to patients' prescribing status in the clinical record, but they did update the record with the information which led to the change.

These two patients had seen a different Spectrum GP about their pain within the next four days. The consultation with the second GP led to prescribing of the same or similar high-risk medicines, in possession, with no reference to previous information on risks or the medicines which had been stopped.

Patient records showed that the regular GP subsequently reviewed these record entries and reviewed the prescribing decisions where appropriate, but the in-possession risk assessment and status was not changed in the patient record.

Is the service effective?

Our findings

We did not inspect this key question during this focused follow up inspection.

Is the service caring?

Our findings

We did not inspect this key question during this focused follow up inspection.

Is the service responsive?

Our findings

At our previous inspection in July 2017 we found that patients were not being consulted when they arrived at HMP Holme House and changes were made to their medicines, particularly medicines for pain management. These changes were being made due to the risks associated with prescribing high-risk pain medicines which include addiction, potential overdose and death.

No information was given to patients about these changes. Patients waited up to five weeks to see the GP, which meant that they were not involved or informed about their treatment and the reasons behind changes, or offered suitable alternatives. Complaints data showed there were high numbers of complaints about prescribing prior to our July 2017 inspection.

Responding to and meeting people's needs

During this inspection we reviewed the provider's action plan and policy to ensure that where changes to prescribed medicines were made, patients were appropriately informed and offered alternative treatment in a timely manner. This included generating a personalised letter using generic letter templates to inform patients where changes of medicines were made.

We saw that prisoners were no longer received direct from courts and police custody, so there were no longer significant medicine changes on arrival into HMP Holme House. Healthcare staff had access to current healthcare records and could ensure continuity of relevant medicines for prisoners who arrived from other prisons.

The evidence we reviewed during this inspection showed that where there were changes to medicines, these were either discussed with the patient in a consultation, or the GP sent a letter to the patient. The letter explained the changes which had been made and the reasons and offered the patient the opportunity to discuss these changes and alternative safe prescribing at an appointment. A review appointment was also offered in four to six weeks, though many patients chose not to attend these.

We spoke with the GP for the service, who explained that letters had always been sent to patients where changes were made, but recognised that in 2017 this had not been happening where changes were made for patients who had arrived as new receptions into the prison.

Access to the service

During this inspection we looked at the waiting lists for GP appointments, and we found that patients were no longer routinely waiting for up to five weeks to see a GP. The GP waiting time was between two and three weeks for routine appointments. Patients with urgent requests were seen within two days. This meant that if a patient was unhappy about changes to medicines, they could access a GP appointment appropriately to discuss this.

A daily nurse led clinic was in place, so all patients could see a nurse for minor ailments and the nurse could request a GP appointment if they felt this was appropriate.

Listening and learning from concerns and complaints

The improvement in involving patients in their treatment had led to a reduction in the numbers of complaints about prescribing. During our July 2017 inspection data for the previous three months showed that 58 out of 101 complaints had been in respect of medicines, mainly GPs not prescribing pain relief medicines. During this inspection the total numbers of complaints in the previous three months was 38, of which only 12 related to medicines, the majority of which were about errors rather than pain relief. This corroborated the improvements which had occurred in this area.

Is the service well-led?

Our findings

We did not inspect this key question during this focused follow up inspection.