HMP Woodhill

Quality 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.

Summary of this inspection

Detailed findings from this inspection

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We did not inspect the safe domain in full at this focussed inspection.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety for patents.
- The trust had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and managed appropriately.
- The in reach mental health team was insufficiently staffed. The primary healthcare team had a number of vacancies that were covered by regular agency staff.

Are services effective?

We did not inspect the effective domain in full at this focussed inspection.

- Staff completed appropriate assessments of patients' health care needs.
- Care planning and the management of risks for patients was embedded within the service and central to the way in which staff worked with patients.
- Staff were sufficiently knowledgeable and skilled to deliver safe effective care.
- Appropriate patient records were maintained.
- Compliance with mandatory and other training was effectively monitored.
- The way in which staff worked with other health care professionals in response to patients with complex health, needed further development.

Are services caring?

We did not inspect the caring domain in full at this focussed inspection.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the available services was easy to understand and accessible, though not readily available in alternative languages.

Summary of findings

- Care planning and the involvement of patients who accessed services was well developed.

Are services responsive to people's needs?

We did not inspect the responsive domain in full at this focussed inspection.

- Patients had good access to primary healthcare services. However, patients with mental health issues did not have equitable access to mental health services.
- Information about how to complain was available and evidence showed that the trust responded to complaints in a timely manner.
- A coordinated response to patients' health care needs required ongoing development.

Are services well-led?

We did not inspect the well-led domain in full at this focussed inspection.

- The trust had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and staff felt supported by management.
- Regular internal governance meetings were held to review and monitor service delivery. This included arrangements to monitor and improve quality and identify risk.
- There was a strong focus on continuous learning and improvement at all levels.
- Internal audits were undertaken and used to monitor quality and to make improvements to service delivery.
- There were good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Summary of findings

Areas for improvement

Action the service MUST take to improve
The areas where the provider must make improvements are:

The trust must ensure that the primary healthcare and the mental health team are fully staffed in order to meet the needs of patients.

Action the service SHOULD take to improve
The areas where the provider should make improvements are:

- The way in which staff worked with other health care professionals in response to patients with complex health needs should be developed further.
- The trust should review patient referral arrangements to the mental health team. Currently prisoners cannot self refer. In its current arrangement this meant that prisoners with mental health issues or concerns did not have equitable access to mental health services.

Outstanding practice

We saw one area of outstanding practice:

- Although not commissioned, the trust had in response to concerns about the number of deaths of prisoners in custody extended its service to cover weekends. This was to ensure that prisoners coming into the prison at the weekend received a full health screen and early days in custody assessment, which contributed to keeping vulnerable prisoners safe.

HMP Woodhill

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Health and Justice inspector, accompanied by a second Health and Justice Inspector. The team had access to remote specialist advice throughout the inspection.

Background to HMP Woodhill

HM Prison Woodhill is a Category A male prison, located in Milton Keynes, England and can accommodate up to 819 prisoners. The prison holds remand and sentenced prisoners aged 18 and above. In addition, Woodhill is one of the eight national high security prisons, holding Category A prisoners, some in the "Closed Supervision Centre".

Central and North West London NHS Foundation Trust (CNWL) provides CNWL provide a full range of primary health and mental health, including emergency response services, first night assessments and prescribing services to the prison population at HMP Woodhill.

Why we carried out this inspection

We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. During our inspection we followed up on some recommended areas for improvement as identified by HMI Prisons during their announced inspection of the HMP Woodhill in September 2015.

We also inspected in direct response to concerns raised by the large number of deaths at the prison and concerns expressed in investigation reports following the deaths of prisons by the Prison Parliamentary Ombudsman.

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a range of information which we reviewed as part of the inspection. We spoke with staff, commissioners' and sampled a range of records. We were on site for three days and during the inspection we looked at provider documents and patient records, spoke with healthcare staff, prison staff and people who used the service.

To get to the heart of patients' experiences of care and treatment on this inspection we asked the following questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

Are services safe?

Our findings

Learning and improvement from safety incidents

- The trust operated an effective system for reporting and recording significant events and all staff were aware of the system and how to report.
- There was a positive reporting culture within the team. Staff could voice concerns through the Datix System and to their line managers. Staff understood reporting processes and escalated incidents and events appropriately.
- There had been a significant number of deaths at HMP Woodhill and the trust had systems in place to undertake thorough analysis of the circumstances of each death.
- The trust completed 'Lessons learned circulars' following investigations into a death in custody and these were shared with the primary healthcare and mental health teams.
- The trust also maintained a 'Lessons learned log', where outcomes from internal external investigations, along with recommendations from the Prisons and Probation Ombudsman were recorded.
- The trust had a lessons learned register and a health action plan where all reported incidents were recorded with actions to address identified risks. Incidents were logged, reviewed promptly and the action plan monitored and updated on a monthly basis.
- Staff had the opportunity to discuss and learn from significant events during weekly team meetings, at one to one managerial supervision meetings and at daily hand over meetings. These meetings provided assurance and opportunities for information from lessons learned was disseminated to the whole staff group.

Staffing and recruitment

- The primary healthcare and mental health teams worked together to meet patients' needs, they were a committed and enthusiastic group of professionals with good access to a supportive management team.
- The primary healthcare and mental health teams had experienced staffing shortages for a significant length of time. The primary healthcare team operated with a 51% vacancy rate. The mental health team consisted of three registered nurses and an interim deputy head and a clinical lead for mental health, which was insufficient to meet the needs of the prison population at HMP Woodhill.
- There were arrangements in place for planning and managing the number of staff and teams' skill mix needed to meet patients' needs, which included the use of regular agency staff to fill gaps in the primary health care team.
- The mental health team did not use agency staff. Essentially this meant that the relatively small mental health team, made up of three nurses and a team lead, was providing a 'crisis' service to the prison population. It was a concern that due to only three mental health nurses employed, there was the potential risk that the management of patients' mental illness may not be fully met. Whilst we were assured that patients in crisis were seen promptly, we were concerned that patients with enduring mental ill health who required access to effective secondary mental health services may not have their needs met.
- The team responded promptly to all mental health referrals with many patients being discharged after one appointment if they didn't have a diagnosed and enduring mental illness or personality disorder. We were told that these prisoners would be signposted to alternative support, for example, GP and or self help literature. The team did not provide regular appointments or accept people on their caseloads who were suffering from 'low level stress or anxiety', sometimes due to detoxification or substance misuse treatment. These patients were seen by the substance misuse team.
- The mental health team did not offer a full range of therapeutic activities due to a lack of staff and stretched resources. At the time of our inspection three patients were waiting to see a psychologist. An assistant psychologist had been recruited and their appointment was imminent. The impact of the reduced staffing meant that little therapeutic group work took place and there was limited availability of direct one to one work with patients.

Are services safe?

- We observed that there were a number of patients who were subject to a Care Programme Approach (CPA) under the Mental Health Act 1983 and six monthly reviews did not take place on a regular basis
- The trust had and was in the process of recruiting nursing staff, mental health practitioners and psychology staff into vacant posts, but these staff were not yet in post and therefore the impact of their appointment could not be assessed at this inspection.

Monitoring risks to patients

- The trust had a lessons learned register and a health action plan where all reported incidents were recorded with actions to address identified risks. Incidents were logged, reviewed promptly and the action plan was monitored and updated on a monthly basis.
- We found that risks to patients were assessed and well managed and risk assessments for patients who used and engaged with the service were routinely completed, reviewed and updated to reflect changes in patient need.
- Daily lunchtime team meetings took place and all members of the teams attended. Information of concern about patients was shared during these meetings. Individual patients identified as being at risk were discussed along with planned interventions, including their clinical management and treatment.
- Referrals to the primary mental health team for a mental health assessment were reviewed daily and prioritised by the interim deputy head and clinical lead for mental health.
- Patients on constant watch were monitored, as were patients on an open, 'Assessment, Care in Custody and Teamwork', document (ACCT). ACCT is a process within the prison system that helps to identify and care for prisoners at risk of suicide or self-harm, through a care planning and review process. Regular ACCT reviews were held on all identified vulnerable prisoners and all professionals involved in the care and treatment of a prisoner, including health care services are expected to attend to assess and monitor the care and treatment needs of a prisoner.
- It was the practice in accordance with the trusts, 'Local Operating Procedure – Mental Health Service Delivery', that nursing staff would attend a first meeting of an ACCT review and where there were serious concerns due to a patient's complex care needs and/or presentation. We were told that requests by operational prison staff for nurses to attend an ACCT review could sometimes be difficult, for example, if reviews were scheduled to take place during medicines administration. However discussions were taking place between the prison safer custody team and the trust to improve the timings of ACCT reviews to ensure nursing staff could attend.

Overview of safety systems and processes

- The trust had systems and processes in place to keep patients safe and safeguarded from abuse. Policies were accessible to all staff. Safeguarding policies clearly outlined who to contact for further guidance if staff had concerns about a prisoner/patient's welfare. Staff had received training on safeguarding children and vulnerable adults relevant to their role.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- The trust provided a full range of primary health and mental health, services to the prison population at HMP Woodhill. This included emergency response services, reception screenings, first night assessments and symptomatic relief of withdrawal and substitute prescribing, in line with the memorandum of understanding between the trust and Westminster Drugs Project, who were the substance misuse provider within the prison.
- During this inspection we focused on the health screen and assessment process that was in place for prisoners received into the prison as we wanted to get an understanding of what was in place for vulnerable prisoners, those with an identified mental illness and for those prisoners with a history and or current attempts of self harm and or suicide. We found that in conjunction with the prison and safer custody team the trust had reviewed the reception screening tool and process to ensure a greater focus on mental health and learning difficulties. The overall aim was to make early days in custody safer and that the combined approach would ensure that prisoners' physical and mental health needs were comprehensively assessed at the earliest opportunity.
- All prisoners received into the prison were seen in the first night centre where a full primary and a mental health screen was completed within 24 hours of their reception into the prison and an assessment of their substance misuse needs within 48 hours or sooner. All prisoners were seen by a mental health practitioner who completed an 'early days in custody screen', which determined if a further mental health assessment was needed. Where the need for follow up was identified, a referral was made to the mental health team for a further and more detailed assessment. Health screen records that we viewed provided a good level of detail.
- The trust had reviewed the health screen assessment template and this now included more detail on a prisoners mental health, a history self-harm and suicide, current self harm, whether they had been subject to an 'Assessment, Care in Custody and Teamwork', document (ACCT), if they had any substance misuse issues, family support and the nature of their crime. This thorough assessment of a prisoner's health and emotional wellbeing at the point of reception into the prison provided a basis for assessing and managing prisoners at risk during early days in custody and assisted in planning the level of long-term support.
- Nursing staff we spoke with confirmed the process and told us that one of the noticeable and positive outcomes for prisoners since the introduction of the new screening process, was that they were seeing less episodes of prisoners experiencing severe mental health crisis during their sentence.
- The reception screen also identified any physical health needs and appropriate referrals were made.
- The trust operated and managed a 13 bed inpatient unit within HMP Woodhill. Whilst the inpatient unit was not the focus of this inspection we did observe that there was a clear admission and discharge procedure in place and this prevented the inpatient unit being used to place prisoners that did not have a healthcare need. The trust also informed us of their plans to open a 12 bed mental health inpatient unit in conjunction with the governor of HMP Woodhill. The trust felt this initiative would help to meet the needs of those prisoners with complex and enduring mental health needs and in particular those prisoners who could wait a long time to be transferred to secure hospital accommodation in the community.

Management, monitoring and improving outcomes for people

- Patients known to the primary health care and mental health teams were discussed at weekly team meetings and daily lunch time meetings.
- A complex cases meeting was held weekly that was GP led, where some patients with complex needs were reviewed; though not all healthcare partners attended.
- We were told that joint working arrangements for patients with complex care needs had recently been reviewed. For patients with a number of health care needs, including physical health, enduring mental health needs and substance misuse issues, it had been recognised that there was a need for all service providers involved with the patient to meet periodically to discuss and review the patient's care. The trust in

Are services effective?

(for example, treatment is effective)

partnership with the substance misuse provider had started to meet weekly to discuss such patients. This was a newly formalised arrangement and we did not have the opportunity to assess the effectiveness of these meetings at this inspection.

- Care records showed evidence of patients' care and treatment plans being reviewed on a regular basis and in response to changes, for example, those patients who were subject of an 'Assessment, Care in Custody and Teamwork', document (ACCT). We saw good recordings on care records which demonstrated clear and regular communication of patients' needs by prison staff to nursing staff.
- Arrangements were in place to monitor and follow up on non-attendance at appointment, known as 'Did not attend' or 'DNA'. The trust had completed a range of DNA audits for various clinics, including GP clinics. Nurses told us that all DNA appointments were followed up, in particular for non-attendance for medicines and appointments with mental health practitioners.

Effective staffing

- Staff had the skills, knowledge and experience to deliver effective care and treatment to the prison population at HMP Woodhill, but reduced staffing levels meant they could not to provide a full range of services.
- Staff were trained and supported to perform their role. Staff were up to date with mandatory training, for example, safeguarding, enhanced life support for clinical staff, intermediate life support for managers, mental capacity act and ACCT foundation training. Evidence we reviewed showed that 90% of the staff group had completed training in suicide and self harm.
- Staff were well supported and had access to formal clinical and managerial supervision. There were good informal systems of supervision available to staff and staff told us they felt supported. We sampled supervision records of primary healthcare staff and we were assured by the Head of Healthcare that systems were also in place for the supervision of mental health staff, which included managerial and clinical group.

Coordinating patient care and information sharing

- Information needed to plan and deliver care and treatment was available to all healthcare staff including GPs in a timely and accessible way through the patient record system, known as SystmOne. This included care and risk assessments, care plans, medical records and investigation and test results.
- During our inspection primary mental healthcare staff expressed frustration at not being able to access the records of sessions that had taken place between substance recovery practitioners and patients. They expressed frustration at not knowing the detail of work that was taking place and how this might impact or influence the work they were undertaking with a patient. We brought this to the attention of the head of healthcare and the head of substance misuse services and discussed the need for improved communication between the two teams.
- We found that there where one or more health professionals were involved in a patient's care, particularly those with complex needs that required ongoing treatment, a multidisciplinary approach to meeting these patients' needs was lacking. However a recent initiative whereby trust staff attended a weekly substance misuse provider meetings to discuss patients with complex health needs including, associated mental ill health and/or substance misuse was a welcome development, as was the development of the interagency integrated clinical governance meeting, the first of which was held on 26 September 2016.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

- We observed members of staff were courteous towards patients and treated them with dignity and respect at all times.
- Patients we spoke with were positive about their contact and experience of healthcare services within HMP Woodhill. They told us they received good information on healthcare services and how to access them when they first came into the prison, including mental health services.They told us that nursing staff were helpful and approachable.
- Patients' opinions of the treatment they received were largely positive, though some patients expressed dissatisfaction with not being able to access specific pain relief medication.
- Patients told us they were very happy with the support they received from healthcare prior to their release including support with medicines management and how to access community healthcare services upon their release.
- Information for patients about the services available was easy to understand and accessible, though not readily available in alternative languages nor was there information in alternative languages about the availability and function of language line.

Care planning and involvement in decisions about care and treatment

- We saw that care plans were personalised and were reviewed on a regular basis and showed good evidence of patient involvement.
- Patient consent was sought, gained and recorded on patient care records.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- All prisoners received a comprehensive physical and mental health assessment, known as a 'health screen' within 24 hours of their reception into the prison. This ensured that prisoners physical and mental health needs were comprehensively assessed at the earliest opportunity, care and treatment plans put in place, risks assessed and monitored.
- Patients physical and mental health needs were followed up and relevant referrals made, for example, access to blood borne virus clinics and mental health assessments. Long term conditions were managed in liaison with the GPs. Prisoners were able to access physical health care services by completing an application form or by speaking to a wing based nurse.
- The mental health team in HMP Woodhill aimed to provide an integrated mental health service, providing primary mental health and the secondary mental health services. The team undertook urgent assessments, crisis management and routine assessments, but due to staffing restrictions was unable to provide regular short term interventions, regular psychological interventions, and Care Programme Approach (CPA) reviews.
- Referral to the mental health team could be made at any point during prisoner's time in custody and could be made by prison officers, governors, or health professionals. However prisoners could not self-refer to the mental health team, but had to request a referral through their relevant wing based nurse. We questioned the appropriateness of this and it's potential to act as a barrier or deter prisoners from asking to see a mental health practitioner.
- We reviewed patient care records, including health screens, care plans and risk assessments and found records were completed in a timely manner, were of good quality and patients' needs were documented. Care planning was well developed, patients consent was sought and recorded and care records showed good evidnence of patient involvement.
- Systems were in place to follow up patients that failed to attend appointments and those who failed to attend for their medicines.
- Trust staff effectively used the prison safeguarding and ACCT process where they had concerns about a patient.

Access to the service

- Prisoners received an information booklet on what health services were available and how to access them. Despite the primary healthcare team being understaffed we observed that waiting lists to see GPs, to attend asthma clinics and medication reviews were relatively low. Prisoners told us they knew how to access healthcare services and none reported any difficulties.
- Prisoners could self refer to all healthcare services with the exception of mental health services, which meant that patients with mental health issues or concerns did not have equitable access to health care services.
- The trust provided 24 hour care to the inpatient unit and a reduced nursing service to patients located across the prison.Although not commissioned, the trust had in response to concerns about the number of deaths of prisoners in custody had extended its service to cover weekends. This was to ensure that prisoners coming into the prison at the weekend received a full health screen and early days in custody assessment.

Listening and learning from concerns and complaints

- The trust operated an effective complaints and concerns system. Complaints were managed in confidential way. Information was available to patients about how to raise a concern and what their options were if they were dissatisfied with the outcome of the complaint investigation.
- The interim lead for mental health services was responsible for responding to patients complaints. We found that responses were timely, appropriate and addressed the complainants' issues.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

- The trust had a clear vision to deliver high quality care and was focused on promoting good outcomes for patients who used healthcare services within HMP Woodhill.

Governance arrangements

- There was a clear staffing structure across health care services within the prison and staff were aware of their own roles and responsibilities. Staffing levels and skills mix along with recruitment were monitored. The trust was proactive in its attempts to recruit nursing staff, mental health practitioners and psychology staff into vacant posts. These staff were not yet in post and therefore the impact of their appointment could not be assessed at this inspection.
- The trust operated an effective system for reporting and recording significant events. Staff had the opportunity to discuss and learn from significant events and we were assured that information from lessons learned was disseminated to the whole staff group.
- The trust had a lessons learned register and a health action plan where all reported incidents were recorded with actions to address identified risks. The action plan was monitored and updated on a monthly basis.
- Clinical and internal audits were undertaken and used to monitor quality and to make improvements to service delivery.
- There were good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The recent development of the 'Interagency Integrated Clinical Governance Meeting' attended by all healthcare providers within the prison, NHS England commissions and the governor for HMP Woodhill was positive action in achieving an overarching prison response to the number of deaths in custody at the prison.

Leadership and culture

- There was a clear leadership structure in place and staff felt supported by management. Staff were involved in discussions about how to develop the service.
- Staff told us there was an open culture across the health care team and they had the opportunity to raise issues at team meetings.

Continuous improvement

- There was a focus on continuous learning and improvement across healthcare services within the prison.
- Audits and daily reports were produced to check that all prisoners received good, effective, responsive care.
- The trust in consultation with its partner agencies was currently reviewing the patient pathway for patients with complex care needs, including those who had a dual diagnosis .
- The thorough assessment of a prisoners health and emotional well being at their point of reception into the prison provided a basis for assessing and managing prisoners at risk during early days in custody and meeting their long term care and treatment needs.

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 18 HSCA (RA) Regulations 2014 Staffing **The primary healthcare and mental health team had experienced staffing shortages for a significant length of time.** **The mental health team provided a 'crisis' service to the prison population. Due to capacity issues the team were unable to provide regular face to face work with patients who required ongoing support because of their mental health needs. Therapeutic group work was limited and CPA reviews did not take place with regularity.**

This section is primarily information for the provider

Enforcement actions

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.