Spectrum Community Health C.I.C.

One Navigation Walk

Inspection Report

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Overall summary

This inspection was an announced focused inspection carried out on 2 May 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 31 July and 4 August 2017.

The July – August 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 12 of the Health and Social Care Act 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/inspections/hmp-northumberland-2/

This focused inspection report covers our findings in relation to those aspects detailed in the Requirement Notice dated 21 November 2017. We do not currently rate services provided in prisons.

Our key findings were as follows:

- There was improvement in the way in which GPs managed risks associated with medicines which patients were prescribed in possession but the local policy for the completion of risk assessments was not being followed and clinical reasoning was not well documented.
- Communication around prescribing of methadone and opiate substitute therapy alongside pain relief had improved and patient records clearly documented clinical decision making.
- The GP had implemented comprehensive processes to ensure that tradable medicines were managed safely.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

Improve governance arrangements to provide adequate assurance that the service is being assessed and monitored and that improvements to the quality and safety of the service are being made including:

- Ensuring that the patient clinical record is fully complete and contemporaneous in relation to safe management and prescribing of medicines.
- Monitoring progress against action plans to improve the quality and safety of services and taking appropriate action without delay where progress is not achieved as expected.

Summary of findings

- Working cohesively with other registered healthcare providers to ensure shared governance and audit arrangements are fully effective around areas of joint responsibility, including information from audits.

Background to One Navigation Walk

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

HMP Northumberland is a category C training prison which was formed in 2011 from the amalgamation of HMP Acklington and HMYOI Castington. The site covers several square miles with health services delivered from several locations across the prison. During our visit HMP Northumberland was holding around 1,340 male prisoners.

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

CQC inspected this location with HMIP between the 31 July and 4 August 2017. We found evidence that fundamental standards were not being met and one Requirement Notice was issued to Spectrum C.I.C. for Regulation 12, Safe care and treatment 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 these areas as part of this focused inspection and found that the provider had addressed the issues identified that fell within their control and remit, though there remained areas of governance which required further improvement.

How we carried out this inspection

This focused inspection was carried out by one CQC health and justice inspector and one CQC pharmacist specialist with guidance from a CQC GP specialist clinical advisor.

During this inspection we reviewed the action plan submitted by Spectrum to demonstrate how they would achieve compliance. We also reviewed documentary evidence including minutes of meetings, reports generated from the electronic patient clinical record system and made observations of the areas of risk identified at the last inspection. We also reviewed patient clinical records and spoke with healthcare managers, healthcare staff, the lead GP, the clinical lead for the GP service, the pharmacist and the prison governor.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

Are services safe?

We did not inspect the safe key question in full at this inspection. We inspected only areas identified in the Requirement Notices in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 5 December 2017.

We found that the areas of concern identified during the inspection in July 2017 were now compliant, although there remained one aspect where further improvement was still required.

Are services effective?

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

Are services caring?

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

Are services responsive to people's needs?

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

Are services well-led?

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

Are services safe?

Our findings

Safe and appropriate use of medicines

At our previous inspection in August 2017, we found a number of breaches of regulation in relation to the safe management of medicines. These included:

- GPs did not routinely complete medicines in-possession risk assessments for patients when they prescribed medicines to keep in-possession.
- There was poor communication between GPs in relation to prescribing of opiate substance treatment and contraindicated pain relief.
- Patient electronic clinical records were not being updated with relevant information relating to decisions to prescribe high risk medicines.

These arrangements had significantly improved when we undertook a follow up inspection in May 2018.

During this inspection, we reviewed the provider's action plan and policy to ensure that where prisoners were given medicines to keep in their possession, a risk assessment had been undertaken. This included clinicians completing an electronic risk assessment template within the electronic patient clinical record system. Completing the risk assessment and ensuring that medicines were prescribed safely was a shared responsibility between Spectrum GPs and nurses employed by a second healthcare provider.

Spectrum had provided training on in-possession risk assessments for GPs and nurses employed by the second healthcare provider in January 2018. Managers also informed us there had been issues with the roll out of the electronic risk assessment template, and a new national reception screening template was to be introduced imminently. This was expected to incorporate all aspects of the required in possession risk assessment.

During this inspection, we reviewed 19 patient clinical records and found that in possession risk assessments were not routinely completed in line with local policy. Despite the requirement to do so the electronic risk assessment had only been completed in three of the records we looked at. Recording of further initial risk information by nurses employed by the other health provider was inconsistent. However we saw clear evidence in patient records that GPs had entered an in possession status for all patients prior to prescribing medicines. In three cases we noted that there had been a change of this status within a few days of reception screening but we could not find any documented reasons for this change. The medicines prescribed in these cases were low risk, so were suitable for prescribing in possession.

We spoke with the main GP for the service who told us they used information within the reception screening to inform in possession risk assessment and subsequent prescribing decisions. The information in the reception screening and patient clinical record which we reviewed was sufficient to make a safe decision on in possession status, despite this process not being in line with the new policy and procedure. However, the clinical reasoning for assigning the risk assessment status was not clearly documented in patient clinical records.

Spectrum had completed audits in October 2017 and January 2018 which showed that in possession record keeping did not yet meet policy requirements. Further audits were planned. Evidence in local and regional medicines management meeting minutes and details of joint training demonstrated that the providers were working together to address this issue, despite the lack of the electronic risk assessment template not being routinely completed.

During the inspection we saw that the GP regularly requested a report of patients who did not have a current in possession status recorded. The GP then reviewed these patients and assigned a relevant status, but did not document reasons or complete the risk assessment template.

High Risk and Tradable Medicines

Due to our previous concerns, we reviewed records of patients who had been prescribed opiate substitute therapy alongside pain relief.

We saw clear evidence of improved communication in relation to patients on opiate substitute therapy where there was also the necessity to prescribe pain relief which might be contraindicated. The prescribers had made appropriate entries in clinical records to show they had considered the risks.

Are services safe?

We also looked at the process for managing and prescribing tradable medicines (tradable medicines have a high value in prison environments and there is considerable pressure for prisoners to sell, trade or give them away).

The GP explained the process for managing tradable medicines and showed us how a multi-disciplinary approach between healthcare providers and the prison led to safer prescribing.

We saw entries in patient records and letters written to patients where there was evidence that high risk and tradable medicines were not being used appropriately. These letters were individually tailored in each instance and included informing the patient of risks associated with misuse of medicines and any national guidance related to prescribing of the medicines. The letters included details of any changes to medicines, an explanation as to the reasons for changes to medicines and an offer for the patient to discuss these changes with a GP.

This process and the monitoring of high risk and tradable medicines had reduced the risks of potential overdose or serious incidents as a result of prescribing.

Are services effective?

(for example, treatment is effective)

Our findings

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

Are services caring?

Our findings

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Are services well-led?

Our findings

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