HMP Lewes - Prison Healthcare Department

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

Between 21 and 23 October 2019, we carried out an announced focused inspection of healthcare services provided by Sussex Partnership NHS Foundation Trust at HMP Lewes.

Following a joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in January 2019, we found that the quality of healthcare provided by Sussex Partnership NHS Foundation Trust at this location required improvement. We issued Requirement Notices in relation to Regulation 9: Person-centred care, Regulation 17: Good governance, and Regulation 18: Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this focused inspection was to determine if the healthcare services provided by Sussex Partnership NHS Foundation Trust were now meeting the legal requirements of the above regulations, under Section 60 of the Health and Social Care Act 2008.

We do not currently rate services provided in prisons.

At this inspection we found that:

- The provider had made some improvements to the systems for managing patients with long-term health conditions. However, a significant backlog of patients still required improved support.
- Not all patients with an identified long-term health condition were prioritised for review when their clinical history indicated on-going need.
- Completion rates for secondary, comprehensive health assessments for newly-arrived prisoners were poor, increasing the risk that immediate health needs may not be identified or adequately addressed.
- Long-term health conditions clinics were scheduled regularly but not always effective owing to staffing, patient non-attendance and unfilled appointments.
- Patients waited too long between an initial triage and a comprehensive assessment of their needs.
- Many patients now had care plans in place, although some were generic and not sufficiently personalised to inform the patient's on-going care.
- Patients with long-term health conditions who attended the specialist nurse's clinic for assessment received structured and personalised support.
- The accuracy and oversight of patient registers had improved since our last inspection, although further work was needed to resolve some discrepancies.
- Staff did not consistently rebook patients who had not attended their planned appointments, which delayed care and treatment and impacted on performance reporting.
- The timeliness of mental health assessments and subsequent access to specialist interventions had improved significantly.
- There was an effective system in place to promptly process health applications.
- Patients routinely had in-possession medication risk assessments completed and recorded in their clinical record.
- The provider had improved their analysis of non-attendance at health appointments.
- The provision of formal staff supervision had improved, particularly for primary care staff.

The areas where the provider **must** make improvements are:

- Prioritise patients with an identified long-term health condition for review when their clinical history indicates on-going need.
- Improve the completion rate of prompt comprehensive health assessments to ensure that patients' immediate health needs are identified and adequately addressed.
- Accurately record patient non-attendance at health appointments and consistently rebook patients to ensure that care is delivered in a timely way.

The areas where the provider **should** make improvements are:

- Continue to review patient registers to ensure they accurately reflect the current patient population.
- Plan dedicated long-term health conditions clinics effectively.
- Personalise care plans for all patients with long-term health conditions to inform their on-going care.
- Improve oversight of staff recording of patient attendance at appointments.

Our inspection team

Our inspection was completed by two CQC health and justice inspectors.

Before the inspection we reviewed a range of information that we held about the service. Following the announcement of the inspection we requested additional information from the provider, including an updated service improvement plan relating to the January 2019 inspection, which we reviewed.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff, prison staff, NHS England commissioners, people who used the service, and sampled a range of patient records and other documents.

Background to HMP Lewes - Prison Healthcare Department

HMP Lewes is a local category B prison located in Lewes in East Sussex. The prison holds up to 692 remanded and sentenced adult prisoners. The prison is operated by Her Majesty's Prison and Probation Service.

Sussex Partnership NHS Foundation Trust provides primary healthcare, inpatient, pharmacy and mental health services at HMP Lewes. The trust is registered to provide the following regulated activities at this location: Treatment of disease, disorder or injury, and Diagnostic and screening procedures.

Our last joint inspection with HMIP was in January 2019. The inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/05/Lewes-Web-2019-1.pdf

Are services safe?

We did not inspect the safe key question at this inspection.

Are services effective?

Monitoring care and treatment

At our last inspection, we found that patients with long-term health conditions were not managed in line with national guidance and did not have care plans in place to inform their on-going care. There were no regular clinics to review and manage long-term health conditions. Patients were not always prioritised when their clinical history indicated on-going need, leading to a deterioration in some patients' health. Patient registers and waiting lists were not up to date and did not reflect the current population.

During this focused inspection, we found that the provider had made some improvements to the processes for managing patients with long-term health conditions. However, a significant backlog of patients remained who required improved support for their needs:

- The provider had seconded a nurse with specialist training in long-term health conditions following our last inspection to help develop the service and support local staff. The nurse was currently working for three days a week at the prison until November 2019, although previous attendance was variable due to other work commitments.
- The specialist nurse had developed a standard operating procedure and algorithm to provide structure and promote consistency in the management of patients with long-term health conditions.
- Primary care staff had received specific training around diabetes, hypertension and respiratory care. Further planned training in long-term health condition management was delayed owing to an external cancellation but was due to resume before the end of 2019.
- The specialist nurse had developed registers for patients with long-term health conditions on SystmOne (the electronic clinical recording system) to help staff record and monitor patients from the point of their initial health assessment. Recording accuracy and management of patient registers had improved since our last inspection, although further work was needed to resolve discrepancies between local registers and the Quality and Outcomes Framework (a national framework used to monitor the management of patients with long-term health conditions).
- The specialist nurse had reviewed patient records and remotely triaged most patients with long-term health conditions. However, patients waited too long between this initial triage and a comprehensive assessment of their needs, with 132 patients still requiring a full assessment at the time of our inspection.
- Patients who attended the specialist nurse's clinic for assessment received good support, evidenced by a thorough health needs assessment questionnaire and personalised care plan, in line with national guidance.
- A dedicated clinic to review patients with long-term health conditions was scheduled twice-weekly. However, this clinic was not always effective owing to staffing, unfilled appointments and patient non-attendance. Between the beginning of August 2019 and our inspection, only 16 of 24 planned clinics took place. Of 128 available appointments during this period, only 35 patients were reviewed and clinic spaces were not always fully booked by the provider. The provider told us they continued to have difficulty accessing patients from the prison owing to prison regime and staffing constraints, and a lack of clinical space on the prison wings.
- Staff did not consistently rebook patients not able to attend their planned appointment, which further delayed care and treatment. Between the beginning of August 2018 and our inspection, 18 patient records were not updated to show whether the planned appointment took place. Managers told us that they monitored the clinic schedule to ensure that patients were re-booked, but we found cases where this had not happened.
- Most patients now had care plans attached to their clinical record on SystmOne following the specialist nurse's remote triage. However, many care plans were added before the specialist nurse had met with the patient to assess their individual needs. This meant that the care plans were generic and not sufficiently personalised to inform the patient's on-going care.
- As at our last inspection, not all patients with an identified long-term health condition were prioritised for review when their clinical history indicated on-going need. We found examples of two patients diagnosed with epilepsy who had not received any structured support before their health deteriroated. The provider planned to review all epileptic patients and train staff to better manage their care, but progress was limited at the time of our inspection.
- At the end of our inspection, the provider presented a recovery plan to address the backlog of patients requiring a long-term health condition review, and

Are services effective?

shared this with healthcare partners and the prison to promote support in accessing patients. This plan included running five additional clinics for seven weeks with additional staffing resources, and increased oversight from service managers including a weekly progress report for CQC. While this additional focus was welcome, we were unable to evidence the impact of these changes during our inspection.

Effective needs assessment, care and treatment

At our last inspection, we found that records of risk management for patients keeping prescribed medicines in their possession were incomplete. In February 2019, 121 of the eligible 403 patients receiving in-possession medication did not have completed risk assessments attached to their electronic clinical record.

During this focused inspection, we found that patients now routinely had in-possession medication risk assessments completed and recorded in their clinical record:

- Health staff completed in-possession medication risk assessments routinely for all new arrivals at the prison and recorded on SystmOne when patients declined an initial assessment.
- All 466 patients receiving in-possession medication at the time of our inspection had completed risk assessments attached to their electronic clinical record.
- Healthcare managers reviewed compliance on a weekly basis and followed up any gaps promptly with staff. Compliance was also monitored at regular medicines management meetings.

During this focused inspection, we found that completion rates for secondary, comprehensive health assessments for newly-arrived prisoners were poor. This posed a risk that prisoners' immediate health needs may not be identified or adequately addressed:

- Completion rates for secondary, comprehensive health assessments within the provider's target of 72 hours of prisoners arriving at the prison averaged 18% from July to September 2019. This was significantly lower than during our last inspection in January 2019. The provider told us that continued difficulty accessing patients from the prison, owing to prison regime and staffing constraints and a lack of clinical space on the prison wings, had impacted on screening rates.
- Many prisoners did not receive a secondary health assessment within the national target of seven days after arriving at the prison. In September 2019, only 39% of new arrivals at the prison received a secondary health assessment within this timeframe.
- The nurse responsible for completing secondary health assessments ran a daily clinic, and attempted to access patients on the wings if they did not attend. The nurse told us that they were training other staff to complete secondary health assessments. However, progress was limited at the time of our inspection.

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Effective staffing

At our last inspection, we found that the provision and uptake of clinical and managerial supervision was inconsistent across the service, particularly amongst primary care staff who had not accessed formal managerial supervision for around four months.

During this focused inspection, we found that the provision of formal staff supervision had improved:

- Access to regular individual supervision had improved, particularly for primary care staff. In September 2019, 87% of all health staff received individual managerial supervision, which exceeded the trust's target of 85%. Compliance across healthcare teams averaged in excess of 80% in the three months before our inspection.
- The provider had improved local systems to monitor supervision compliance and record this in the electronic staff record. Managers appropriately followed up any gaps in supervision.
- Weekly reflective practice group sessions were embedded and well received by staff, although some told us that they had difficulty accessing these sessions as they clashed with clinics, which took priority.
- Staff gave us mixed feedback around the support that they received from managers and access to supervision. However, all staff records that we reviewed evidenced regular, formal supervision. We also saw evidence of good visibility from local managers and senior managers from the trust, who were supporting staff during on-going changes to the service.

Are services caring?

We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?

Timely access to care and treatment

At our last inspection, we found that the mental health team were not meeting patients' needs in a timely way. Patients on the mental health waiting list waited up to four months for a full assessment of their needs and there was a risk that these patients could deteriorate significantly before coming to the attention of staff. Patients who had been assessed as requiring clinical intervention waited too long for an appointment with a psychologist or psychiatrist, waiting up to two and four months respectively.

During this focused inspection, we found that the timeliness of mental health assessments and subsequent access to interventions had improved significantly:

- The provider had revised the mental health triage and assessment systems to ensure more effective oversight of prisoners awaiting an assessment. Staff triaged patients on the same day where possible, and the service's crisis team supported immediate needs out of hours. A live document had replaced the patient waiting list and staff reviewed this regularly to ensure that patients were prioritised for assessment according to need.
- The mental health team used a weekly allocation meeting and multidisciplinary meeting attended by the psychiatrist to review patients and prioritise them for support based on need.
- The longest wait for a mental health assessment at the time of our inspection was 34 days, which was an improvement from our last inspection. This patient had received periodic support from mental health staff while awaiting an assessment.
- Improved staffing levels in the mental health team since our last inspection had contributed to the improvements seen, with five additional staff now in post.
- Patients now had prompt access to interventions after being assessed as requiring specialist support. Two patients waited up to 14 days for a psychology appointment, and seven patients waited up to 35 days for a psychiatry appointment. This was a significant improvement from our last inspection.

Are services well-led?

Governance arrangements

At our last inspection, we found that the system for managing prisoner applications for health appointments was ineffective and impacted significantly on prisoners' timely access to care and treatment; we found 143 unactioned healthcare application forms dating back almost two months.

During this focused inspection, we found that there was now an effective system in place to promptly process health applications:

- The provider had implemented an effective process to support staff processing healthcare applications, supported by clear documentary guidance.
- Applications that we tracked during this inspection were processed within the provider's local target of 24 hours. The application in-tray was checked daily by managers to ensure forms were actioned without delay.
- Although compliance with the 24-hour target was variable, the provider had improved systems to monitor and report on compliance, including a weekly performance report. Managers were aware of reasons for non-compliance and appropriately followed up any delays directly with staff to improve performance.

At our last inspection, we found that there was no effective oversight and analysis of the reasons for non-attendance at health appointments. Reasons for non-attendance were not routinely recorded on SystmOne, and re-booking of patients who did not attend was inconsistent.

During this focused inspection, we found that the provider had improved their analysis of non-attendance, although reporting accuracy was affected by inconsistent recording on SystmOne by some staff:

- The provider had improved processes for monitoring and reporting on patient non-attendance at health appointments. This included joint working with prison officers to record non-attendance reasons, adding health applications to the prison's management system to remind officers to bring patients to appointments, and regular managerial oversight via a local performance dashboard.
- The provider shared a report which analysed trends and gave recommendations to improve access with the prison through operational meetings. A newly-arranged local delivery board meeting would provide further opportunity for the provider to address difficulties in accessing prisoners for health appointments.
- Some staff did not consistently rebook patients who had not attended their planned appointment, which impacted on the accuracy of non-attendance reporting. We found cases where appointments had been left open on SystmOne, which meant it was not known if the patient had attended, or the reason if not. Improved management oversight of recording on SystmOne was required.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Patients with an identified long-term health condition were not always prioritised for review when their clinical history indicated on-going need. • New patients did not receive a prompt comprehensive health assessment to ensure that their immediate health needs were identified and adequately addressed. • Staff did not consistently record patient non-attendance at health appointments and rebook patients who did not attend to ensure that care was delivered in a timely way.