HMP Forest Bank

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 inspection. We inspected only those aspects mentioned in the Requirement Notices issued in February 2016.

- The inpatient unit continued to be staffed by one registered mental health nurse. Nurses told us they were frequently called away from the inpatient unit to see prisoners located on the wings. This meant that 24 hour nursing care was not provided and this restricted the amount and quality of nursing support offered on the unit, potentially putting patients at risk.
- Clinical and emergency equipment was maintained and fit for use.

Are services effective?

We did not inspect the effective domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in February 2016.

- We found non-attendance rates at secondary health screens remained high. For example between June and November 2016, 58% of prisoners failed to attend a secondary health screen appointment which was a significant concern.
- There was no mental health pathway that included response times and criteria to access the services of the primary mental health team to promote the consistent and effective delivery of care and treatment.
- Most staff received supervision and had access to mandatory training. Some staff told us they felt unsupported by management.
- Concerns about work performance issues were handled confidentially. Annual appraisals for 2016 and 2017 were made available to us for some staff during the inspection.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in February 2016.

Summary of findings

- There had been some improvement in the regime of the inpatient unit. Patients had improved access to showers, exercise arrangements and education. However the range of therapeutic activities provided was still restricted.
- The physical environment of the inpatient area had improved. The unit had been painted and was clean throughout.
- Patients waited too long to access a primary mental health assessment and this was a significant concern.
- Patients with mild to moderate mental health issues did not have access to planned ongoing treatment or psychological interventions comparable with community mental health services.
- A new confidential complaints process was in place and patients received a courteous response to their complaint. However patients were still not provided with information on how they could escalate their complaint should they remain dissatisfied.

Are services well-led?

We did not inspect the well led domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in February 2016.

- The service lacked an overarching governance framework which supported the delivery of quality care.
- The service did not have a programme of continuous clinical and internal audits to monitor quality and to make improvements in the service. For example, care plan audits and audits of clinic waiting lists.
- Staff told us they felt unsupported by management, they did not feel involved and included in decisions about how to run and develop the service.
- There was a lack of joined up working between clinical leads. The service did not provide a cohesive and well integrated service whose aims were to meet the holistic needs of patients.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- The provider must have a safeguarding policy/ protocol that supports staff to recognise and take action if a patient is at risk of harm/abuse or presents a risk to others.
- Staffing levels on the 24 hour inpatient unit must be monitored to ensure that a safe and effective service is provided to patients and meets their needs.
- Attendance at secondary health screening appointments and waiting times for primary mental health services should be monitored to ensure that prisoners' health needs are identified and met.
- The provider did not have a complaints policy. Patients must be provided with information on how to escalate concerns and complaints if they remained dissatisfied with the outcome of their complaint. The new complaints system must be published across the prison.

Action the service SHOULD take to improve

- Patients with mental health needs should have access to psychological therapies equivalent to community services.
- Staff should have the opportunity to provide feedback on the day to day operation of the service and be included in decisions about how the service is ran.

HMP Forest Bank

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC health and justice inspector, accompanied by a Her Majesty's Inspectorate of Prisons healthcare inspector.

Background to HMP Forest Bank

Forest Bank is a category B local prison in Salford and accommodates up to 1,500 adult convicted and unconvicted prisoners. The prison is managed by Sodexo Limited who are also responsible for the provision of primary healthcare services, primary mental health services, inpatient facilities and substance misuse services within HMP Forest Bank.

The location, HMP Forest Bank is registered to provide the regulated activity, treatment of disease, disorder or injury.

CQC inspected healthcare services at the prison in partnership with Her Majesty's Inspectorate of Prisons from 15 to 18 February 2016. We found the provider was in breach of the regulations and we issued three Requirement Notices. We asked the provider to make improvements and we followed up on their progress during a focused inspection on 7 and 8 December 2016.

During this focused inspection, we found the provider had made some improvements in some areas and insufficient improvement in other areas since the joint inspection in February 2016. The provider had met one of the regulations which they had previously breached. They had partly met one of the regulations, and failed to meet a third regulation they had previously breached.

The provider remains in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment and Regulation 16 Complaints. We have issued an additional Requirement Notice in respect Regulation 17 Good governance.

Our key findings across all the areas we inspected in December 2016 were as follows:

- The majority of staff had completed training in safeguarding adults and child protection.
- The physical environment of the inpatient unit had improved and this better supported patients' dignity and respect.
- Clinical and emergency equipment was maintained.
- An admission and discharge policy to the inpatient unit had been developed and covered both mental health and physical health.
- The majority of staff had access to regular supervision and ongoing support.
- A new complaints process had been developed and responses to complaints were courteous.

Why we carried out this inspection

We undertook a focussed inspection under Section 60 of the Health and Social Care Act 2008. The purpose of the inspection was to follow up on Requirement Notices that we issued following an inspection in February 2016 and to check that the provider was meeting the legal requirements and regulations associated with the Act.

Detailed findings

How we carried out this inspection

The inspection was led by a CQC health and justice inspector who was accompanied by a HMI Prisons healthcare inspector.

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. During the inspection we spoke with staff and patients who used the service.

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

- Is it safe?
- Is it effective?
- Is it responsive to people's needs?
- Is it well led?

Are services safe?

Our findings

Overview of safety systems and processes

- In February 2016 we found that the provider did not have a safeguarding adults or child protection policy. Following that inspection the provider sent us an action plan setting out the action they would take to improve and meet the regulatory breaches we found. They told us they would develop a safeguarding adults and child protection policy by 30 November 2016. The provider shared a copy of a draft, Safeguarding Policy and Procedures, Adults, Young People and Children policy with us in November 2016. It is important that a safeguarding policy is developed as soon as possible to support staff in recognising what action to take if they suspect a prisoner is at risk of harm/abuse. The provider sent us a copy of their finalised Safeguarding Policy and Procedures, Adults, and Young People and Children policy following the inspection.
- During this focused inspection we were made aware of a safeguarding incident which we brought to the attention of the provider. A health and social care referral was subsequently made to the local authority by the provider. We were concerned that the provider did not have clearly defined safeguarding processes and practices in place and staff were unsure as to how to respond to information of concern.

Monitoring risks to patients

- The inpatient unit continued to be staffed by one registered mental health nurse. Nurses told us they were frequently called away from the inpatient unit to see prisoners located on the wings, which meant that 24 hour nursing care was not provided and which put patients on the unit at risk. There was the potential that this staffing arrangement could contribute to patients not being allowed sufficient time out of their cell whilst located in this area.

Arrangements to deal with emergencies and major incidents

- We looked at equipment used to respond to medical emergencies. On a previous inspection in February 2016 we found several out of date items and checks to ensure equipment was safe to use were not under taken regularly. At this inspection we found clinical equipment was checked to ensure it was working properly. Daily checks to equipment were recorded. We checked emergency response bags, the contents of which were in date with the exception of one item which we brought to the attention of staff who then removed and replaced the item. We checked emergency drugs and oxygen and found these to also be in date, along with defibrillators.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- At a previous inspection we found that non-attendance rates for secondary health screens were high, which meant that new prisoners did not receive a more detailed health assessment. This posed a risk that prisoners' health needs may not be identified and addressed. At our December 2016 inspection we found that measures had been put in place to promote the uptake of health screens, including health care assistants following up prisoners to find why they hadn't attended. We found appointments were not rebooked following a failure to attend, unless the prisoner had been unable to attend due to court attendance or another conflicting appointment.
- On this inspection we found non-attendance rates at secondary health screens remained high. For example between June and November 2016, 58% of prisoners failed to attend a secondary health screen appointment which remained a significant concern. We were not assured from looking at patient records that all prisoners were listed for a secondary health screen. We found instances where secondary health screens were not recorded ona prisoner's record, and the prisoner had not been put on a waiting list or recorded as 'did not attend'.
- Previously we observed that the initial health screen did not include a learning disability assessment. At this inspection we found that learning disability screening was still not in place, so patients were not referred to learning disabilities services.
- Patients with mild to moderate mental health issues still did not have access to psychological therapies equivalent to community services.
- The appointment of three registered mental health nurses meant that continuity of care had improved and a small number of patients had a care plan, though these were not audited for quality purposes. Overall we observed good levels of patient input but it was not always clear why a patient was seen and others were not.

Management, monitoring and improving outcomes for people

- It wasn't clear who had overall clinical responsibility for patients located on the inpatient unit. Inpatient multi-disciplinary team meetings did not take place and GPs did not routinely review patients' care. Care planning and joint working with a mental health in reach team was limited.
- A weekly mental health forum took place and was attended by the primary mental health team, along with staff from the mental health in reach team, the recovery team, staff from education and safer custody staff. We saw minutes from these meetings which included a number of standing agenda items, such as new referrals, complex cases, prisoners of concern and inpatients.However not all prisoners/patients with complex care needs were discussed at the meeting, which meant that there was the potential that some patients' needs were not being sufficiently managed.
- Previously we found that risk assessments for patients known to the primary mental health team were not routinely completed. At this inspection we found that a new primary mental health referral form was introduced in May 2016, which included questions concerning risk, for example, risk of self harm/suicide. Prisoners can self refer to the service, though the referral form does not advise staff or prisoners what to do if the problem was urgent.

Effective staffing

- The primary mental health team provided cover to the inpatient unit, reception and night duty, and we were told this limited the amount of time nurses had to undertake case work with patients. The health care service within HMP Forest Bank had been re-profiled, and we were told that from January 2017 primary mental health nurses will no longer cover night duty and the team will lose one full time nurse. It is anticipated that the new profile will allow more time for nurses to undertake psychological interventions.
- In February 2016 we found that staff did not receive formal regular supervision and neither did they receive copies of supervision meetings, performance discussions or annual appraisals. During this inspection we found that all staff had received supervision with the exception of a nurse manager who had been appointed in the previous 12 months and had not had a formal supervision meeting. Staff did not always receive regular supervision. We saw that some staff received supervision on a regular basis but for other staff supervision had only taken place in recent weeks prior to our inspection and we observed that one member of

Are services effective?

(for example, treatment is effective)

staff had attended their first supervision session on the day of our inspection. There was no system to ensure that all staff received regular supervision. Staff were offered copies of their supervision record but none had taken this offer up.

- Concerns about work performance issues were handled confidentially. Annual appraisals for 2016 and 2017 were made available to us for some staff during the inspection.
- At a previous inspection we found that staff were not supported to participate and undertake mandatory training. We found that health care staff had not completed training in safeguarding adults and child protection.During this inspection we found that the majority of staff had completed safeguarding training and training was scheduled for a number of staff early 2017.
- At the time of this inspection some staff told us they felt unsupported by senior management. During the course of our inspection we received a whistle blowing alert. The whistle blower alleged that some staff did not access training in a timely way. We found that a number of healthcare staff had completed training, and for others training was scheduled.

Are services caring?

Our findings

We did not look at this domain during the inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- At a previous inspection we saw that the inpatient unit included 10 single cells which were occupied by patients with complex mental health problems. The condition of the cells was poor. At this focused inspection we found that physical environment of the unit had improved. The unit had been painted and was clean throughout.
- An admission and discharge policy to the inpatient unit had now been developed and covered both mental health and physical health admissions to the unit. The policy was clear that admission to the unit was based on clinical need. The policy included guidance for patients who discharged themselves against medical advice. However we were made aware of one patient with mental health needs who was discharged from the inpatient unit against the psychiatrist's instructions whose care records did not detail the reason for their discharge. Records showed that there had been no liaison with the mental in reach team about the ongoing care and treatment for this patient which meant that discharge planning for this patient was poor and compromised the patient/prisoner's safety.
- Patients located on the inpatient unit had better access to showers, exercise and education, and arrangements were in place to support communal dining.However the unit still lacked therapeutic input. Patients on the unit did not have access to psychology services and not all prisoners on the inpatient unit had access to a psychiatrist.

Access to the service

- In February 2016 we found that patients waited three weeks to access the services of the primary mental health team and this was too long. At this inspection we found patients waited longer, up to six weeks, for a primary mental health assessment, although appointments could be prioritised depending on need. This remained a significant concern.
- In February 2016 we were concerned that patients with mild to moderate mental health issues did not have access to planned ongoing treatment or psychological interventions as comparable with community mental health services. At this inspection we found there had been no change or improvement, patients had no access to input from a psychiatrist or to psychological interventions. Patients with mental health needs should have access to psychological therapies as equivalent with community services.
- Two members of the primary mental health team were undertaking motivational interviewing training to be completed in February 2017. It was anticipated that primary mental health staff could then begin to develop patient focused interventions using this technique.

Listening and learning from concerns and complaints

- At the previous inspection in February 2016 we found that the provider did not manage patients' complaints effectively, and there was no information displayed in healthcare that advised patients about how to raise a concern or a complaint.
- Since our last inspection the provider had reviewed the complaints process and a new complaints process had been developed in August 2016. We looked at complaints received in October and November 2016.We saw that 'medical in-confidence' envelopes were now provided and this ensured that patient confidentiality was supported. We saw that most responses to complaints addressed all the issues that the complainant made, were courteous, and when appropriate offered an apology. Whilst responses were timely, in most cases, within two days, responses still did not include information on what options were available to patients if they remained dissatisfied with the response to their complaint.
- The new complaints system was not publicised widely across the prison. Health care information leaflets did not include any reference to how to make a complaint. We were told that the new complaints system was available via the prisoner appointment 'kiosk' booking system. However we, along with two prisoners, were unable to access information on the new complaints system through the prisoner 'kiosk'.
- On a previous inspection we told the provider that they must provide information to patients on how to escalate concerns and complaints if they remained dissatisfied.This information was not in place at the time of our follow up inspection. We were told this would be resolved and this information sent to us imminently. However this information has not been provided.

Are services responsive to people's needs?

(for example, to feedback?)

- We saw an audit of complaints made in October 2016 but were told that no other audits had been completed, although plans were in place to undertake further audits.

Are services well-led?

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

Our findings

Governance arrangements

- The provider was responsible for primary health care services, primary mental health services, inpatient facilities and substance misuse services within HMP Forest Bank. The service lacked an overarching governance framework which supported the delivery of safe, effective, quality care.
- The service did not have key policies and procedures in place to support day to day practice, for example, criteria to access services.
- The service did not have a programme of continuous clinical and internal audits to monitor quality and to make improvements in the service. For example, staffing levels and the quality of care provided to the inpatient unit was not monitored, and audits of complaints and care plans were not undertaken.
- Attendance at secondary health screens appointments and waiting times for primary mental health services were not sufficiently monitored to ensure that prisoners' health needs were identified and met. Whilst attendance rates for secondary health screens were recorded and monitored this information wasn't used to improve the uptake of secondary health screens.

Leadership and culture

- The head of health care was not available at the time of our inspection. We met with three clinical leads, for primary health care, primary mental health and clinical recoveryand the Corporate Clinical Advisor for Justice Services
- Despite the service having a structured leadership arrangement, a number of staff told us they felt unsupported by management. Staff told us they did not feel involved and included in decisions about how to run and develop the service.
- We observed that each clinical area, for example, primary health care, operated in isolation to other parts of the health care service. There was a lack of joined up working between clinical leads. Clinical leads did not always work effectively with other health care providers within the prison.The service did not provide a cohesive and well integrated service whose aims were to meet the holistic needs of patients.
- During this inspection we found that there had been no improvement in the services provided to people with primary mental needs and that the service was not sufficiently monitored, for example, patients continued to wait a long time for a mental health assessment and could not access psychological therapies comparable with those provided in the community. Patients located in the inpatient unit did not have access to adequate therapeutic support to aid their recovery.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The uptake of secondary health screens remained low and there was a risk that patients' needs would not be identified or met. Prisoners had poor access to mental health services and a range of services to meet their needs including psychology and access to a psychiatrist. The service did not provide an integrated service whose aims were to meet the holistic needs of patients. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Patients were not provided with information on how to escalate concerns and complaints if they remained dissatisfied with the way their complaint was handled. The new complaints system was not promoted, and prisoners had limited information on how to make a complaint. This was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients through governance systems and processes.

The service did not have key policies and procedures in place to support day to day practice, including criteria to access services.

We saw an audit of complaints made in October 2016 but were told that no other audits had been completed, although plans were in place to undertake further audits.

Staffing levels on the 24 hour inpatient unit were not monitored to ensure that a safe and effective service was provided to patients.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014