Bridgewater CHCFT HMP Wymott

Inspection report

Wymott Prison
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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

We carried out an announced focused inspection of healthcare services provided by Bridgewater Community Healthcare NHS Foundation Trust at HMP Wymott on the 7 and 8 May 2019.

The purpose of this focused inspection was to determine if the healthcare services provided by the trust were meeting the legal requirements of the Requirement Notices that we issued in July 2018 and to find out if patients were receiving safe care and treatment. At this inspection we found the provider was meeting the regulations.

We do not currently rate services provided in prisons.

At this inspection we found:

- Healthcare staff were appropriately trained, for example, in safeguarding and intermediate life support.
- The availability of chaperones was promoted in healthcare and patients could request a chaperone to be present during examinations.
- The arrangements for managing medicines kept people safe.
- There were more formalised arrangements to share with staff the learning from adverse events.
- Prisoners received an assessment of their immediate and ongoing healthcare needs at the point of reception into the prison.
- Healthcare staff worked together and with other health and social care professionals effectively to deliver care and treatment.
- Prisoners' attendance at healthcare appointments continued to be monitored regularly and analysed.
- Healthcare staff told us since the appointment of the director for health and justice and the acting head of healthcare, they felt better supported and listened to.
- Communication and information sharing with the prison had improved since the appointment of a healthcare governor.
- Managers had put in place a process for supervision, but more time was needed to assess the full impact of the changes.
- Healthcare managers closely monitored mandatory training and the uptake by staff had improved.
- Healthcare managers had effective oversight of key areas of service provision, including the continuation of medicine supplies to patients.
- Healthcare staff held a monthly service user forum. Patients reported good communication from healthcare managers about service developments and improvements.
- The introduction of bi-monthly health and justice bulletins was an effective means to sharing information about key developments in the service and plans for the service.

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

- Inform patients as soon as practicable of the outcome of and results of clinical investigations.
- Ensure that all clinical areas, in which primary healthcare nursing staff provide treatments and medicines, meet infection prevention standards and do not compromise patient safety.
- Continue to monitor dental waiting times, including managing and mitigating the risk to patients.

Our inspection team

Our inspection team was led by a CQC health and justice inspector, accompanied by a CQC health and justice inspector, a health and justice inspection manager, a CQC pharmacist specialist and nurse specialist adviser (SpA).

Before this inspection we reviewed a range of information that we held about the service; for example, action plans we had received from the provider. Following the announcement of the inspection we requested additional information from the trust, which we reviewed.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff, prison staff, commissioners, patients and sampled a range of records.

Background to Bridgewater CHCFT HMP Wymott

HM Prison Wymott is a Category C men's training prison, located in the village of Ulnes Walton, in Lancashire, England. The prison is operated by Her Majesty's Prison and Probation Service. It accommodates up to 1176 adult male prisoners

Bridgewater Community Healthcare NHS Foundation Trust has been commissioned by NHS England to provide primary health care services, including GP and dental services to the prison population at HMP Wymott, since April 2017. The trust is also commissioned by NHS England on behalf of Lancashire County Council, to provide social care services within the prison. The trust is registered with CQC to provide the regulated activities of Diagnostic and screening procedures and Treatment of disease, disorder or injury at the prison.

In July 2018 we undertook a comprehensive inspection of the service in response to concerns and issued five Requirement Notices to the trust. We issued the following Requirement Notices, Regulation 9 Person centred care, Regulation 10 Dignity and respect, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing. The report from the comprehensive inspection can be found on our website at: https://www.cqc.org.uk/location/RY2U2

Are services safe?

At our last inspection, we found not all staff had completed safeguarding training appropriate to their role. The availability of chaperones was not advertised, and prisoners didn't request this service as they were unaware that it existed.

Safety systems and processes

- During this focused inspection, we found that 81% of healthcare staff had completed safeguarding level 2 children, and 81% had completed training in safeguarding level 2 adults. This included nursing staff, healthcare assistants and social care support workers. This was an improvement since our July 2018 inspection when we found 36% of staff had completed this training.
- Posters advertising the availability of a chaperone service were displayed in healthcare waiting and treatment areas. Patients could request a chaperone to be present during examinations, including intimate examinations, although some told us they were not aware that this service was available. One nurse had completed chaperone training and healthcare staff told us they were not aware of any patients that had requested a chaperone.

Risks to patients

At our last inspection, we found risks to patients were not adequately identified, managed or monitored, for example, managers did not keep accurate records of clinics cancelled. Treatment rooms located on wings did not meet infection prevention standards. Regular checks of emergency bags were not always completed. Healthcare staff including nursing staff, pharmacy technicians, healthcare assistants and social care support worker had not completed life support training.

- During this focused inspection, we found the risks to patients were adequately identified, managed or monitored, for example, managers kept accurate records of cancelled clinics and emergency bag checks were completed daily. Healthcare managers now actively monitored and reviewed the service to ensure patient risk was managed.
- We saw copies of staff duty rotas for May 2018, which showed the number of staff on duty. The service was sufficiently staffed to meet the needs of patients at the time of our inspection.
- The service had five Band 5 nursing staff vacancies, one vacancy for a Band 6 practice nurse, one vacancy for a social care support worker and one vacancy for a healthcare assistant. The trust had successfully recruited three nurses who were going through security vetting procedures and had a rolling recruitment process in place. Regular agency nurses were used to fill vacancies and permanent nurses and other healthcare staff told us this assisted with continuity of patient care.
- We found 71% of staff including nursing staff, pharmacy technicians, healthcare assistants and social care support workers had completed basic life support training commensurate with their role and 82% of staff had completed intermediate life support training. Plans were in place to ensure that remaining staff completed this training. This was a vast improvement than on our last inspection when we found that 5% of nursing staff and pharmacy technicians had completed basic life support training and no nursing staff had completed intermediate life support training.
- There was no designated local infection prevention control (IPC) lead within the healthcare team at HMP Wymott however, managers told us that support was available from the IPC lead at a neighbouring prison and from the trust-level IPC lead. The trust lead completed infection control audits twice a year and we saw evidence of further audit activity. Almost all recommendations from the most recent IPC audit had been actioned.
- Since our 2018 inspection treatment rooms had been decluttered. Staff told us that nurses cleaned surfaces daily to ensure their fitness for use. This was not recorded and there was no system in place to monitor this activity and provide the trust with assurance that it was happening. We brought this to the attention of the director for health and justice services at the trust and the acting head of operations during the inspection. They subsequently acted and put systems in place, including staff completing cleaning schedules.
- The trust had recognised that general cleaning arrangements of the healthcare facilities were not sufficiently reliable, and improvements were planned in partnership with the prison, which was an example of positive joint problem solving. Plans included, employment of a dedicated cleaner for the healthcare facilities and the creation of a prison orderly post. The trust acknowledged that IPC standards across healthcare treatment rooms within the prison should be maintained at the same level as external community services.

Are services safe?

Information to deliver safe care and treatment

At our last inspection, we found that health-led multidisciplinary meetings did not take place.

- During this focused inspection, we found the acting head of healthcare had established a complex case review meeting, led by the clinical director and with multi-disciplinary input. The fortnightly meeting was used to review, agree treatment pathways and care plans for patients with complex health conditions and medication issues. The meeting was attended by the prison's healthcare governor, and there were plans to engage other health providers in future meetings to promote holistic care.

Appropriate and safe use of medicines

At our last inspection, we found that competency assessments for pharmacy technicians were not in place. Safe processes for the secure management of prescription pads were not in place. The safe transportation of medicines through the prison was not assured as no prison security was provided. The monitoring and recording of medicine fridge temperatures was an area of concern. We could not be assured that medicines held within fridges were fit for purpose or that medicines administered had been effective due to a lack of monitoring and recording of temperatures. We found that not all patients who held their medicines in-possession had been fully risk assessed and understood the responsibilities of managing medicines.

- During this focused inspection, we looked at the systems in place for medicines management within the prison including medicines optimisation, storage and transport. We found that the arrangements for managing medicines had improved and kept people safe.
- Staff followed processes that ensured prescription stationery was documented and tracked, fridge temperatures were monitored in line with the provider's policy and emergency bag checks were completed daily. Patient group directions were in place, in date and signed by the relevant staff members. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription.
- In possession risk assessments and compact agreements were in place for the 20 people we reviewed. In addition, an in-possession risk assessment audit had taken place which identified recommendations to be addressed going forwards. This was an improvement from the previous inspection.
- Medicines governance arrangements had been implemented and the medicines management group was well attended. Risks and actions were openly discussed which supported continual learning and development. Minutes were available and shared throughout the team.
- A competency framework and assessment was in place that ensured pharmacy technicians were competent to administer medicines.
- Systems in place at the time of this inspection did not sufficiently track the movement of medicines across the prison. We brought this to the attention of the director for health and justice services, the acting head of operations and the prison governor. In response to our concerns the trust in partnership with the prison acted and put in place a standard operating procedure which allowed for medicines to only be transported safely. This meant that medicines were now transported with the security of a prisoner officer escort and during times when prisoners were not present.

Track record on safety

At our last inspection, we found risks to primary healthcare services were not effectively managed. There was a system in place for recording and acting on significant events. However, we were not assured that all significant incidents were reported, and appropriate action was taken to ensure patient safety. We found that reporting processes at local level were variable and it wasn't clear if all incidents were reported or escalated to the trust if they were significant.

- During this focused inspection, we found that systems for recording and responding to significant events were in place. Staff reported incidents and appropriate action was taken to ensure patient safety. Reporting systems were fully embedded at local level and trust level. The introduction of a weekly patient safety meeting were all incidents across the five prisons for which the trust was responsible provided an opportunity to review incidents, take appropriate agreed actions, including escalation to trust level.
- Healthcare services and risks to patient safety were now appropriately monitored by healthcare managers. The trust had a risk register that identified a range of risks

over the five prison sites to which the trust provided healthcare services. A total of 28 risks had been identified, including individualised patient assessment that involved patient participations, staff supervision and the lack of secondary health assessments.

Lessons learned, and improvements made

At our last inspection, learning from adverse events and the dissemination of information to improve safety across the service was not happening. There was no evidence that learning from significant events had been shared with staff.

- At this inspection we saw evidence of more formalised arrangements to share the learning from adverse events with staff. In March and May 2019, a bi-monthly health and justice bulletin had been issued to all staff, which included inspection outcome information and patient safety issues, including deaths in custody and stroke awareness.
- Staff knew how to report incidents both internally and externally and understood they had a duty to raise concerns and report incidents and near misses. They told us there were opportunities to learn from incidents at team meetings and clinical supervision.
- Staff told us that they now felt more comfortable in raising concerns and confident that their concerns would be considered by healthcare managers and the trust. They felt comfortable in reporting any errors or concerns they had about practices that hadn't gone well, and these were used positively to inform improvements. Staff confirmed that they received feedback on the outcome of any incidents they had reported, which gave them confidence that action was taken to prevent a recurrence.
- We sampled a range of records, including team meetings, daily staff handover meetings and group/individual supervision and noted these were used as opportunities to discuss adverse events and the associated learning.

Are services effective?

Effective needs assessment, care and treatment

At our last inspection, we found not all prisoners received a detailed secondary health assessment within seven days of their reception into the prison. Health care assessments within the first few days in prison are crucial in identifying prisoners' healthcare needs, providing treatment and keeping people safe.

- During this focused inspection, we found all prisoners received an assessment of their immediate and ongoing healthcare needs at the point of reception into the prison.
- We found that healthcare staff currently combined the initial reception health assessment and detailed secondary health assessment. This was not in line with guidance from NHS England. Combining the health assessments had the potential to limit patients' interactions with healthcare staff during their early days in prison. This raised the possibility that patients may not receive further support or be kept safe during a period of high vulnerability for many. The head of healthcare told us there were plans to conduct separate health assessments in the future.

Monitoring care and treatment

At our last inspection, we found the supervision and management of social care provision by the trust was unclear. Care planning in respect of prisoners receiving social care support was variable and care support workers did not always maintain a record of patient contact. Patients did not always get their prescribed medicines and there was no medicines optimisation service.

- During this focused inspection, we found social care support was provided by the trust in partnership with Lancashire County Council. The trust employed four fulltime and one part-time social care support workers and these posts were partially funded by the council to provide personal care to 14 clients. The trust was directly responsible for the day to day management and provision of social care support within the prison. We found that care planning for clients that received social care support had improved. Healthcare staff undertook formal reviews of care plans, social care support staff completed social care records daily, inputting care provided in line with care plans.
- Care planning had improved since our last inspection and we were satisfied that effective action had been taken to address the gaps identified in 2018. During this inspection we sampled twenty-nine patient records and were able to confirm that care plans were in place that reflected patients' needs. We also saw evidence that these plans were reviewed at intervals. However, some care plans we sampled required further personalisation to ensure they fully reflected individual needs and preferences.
- Nurses were directly responsible for the management of patients with medical conditions that required ongoing care and treatment, and social care support staff remained directly responsible for providing social care support. Whilst the overall management and leadership of patients located on I wing, which was where older prisoners in receipt of social care support were based, was clearer and stronger there was opportunity for greater joint working to provide a seamless service.
- A GP undertook a weekly ward round on I wing so that patients could be seen on the wing instead of having to be brought to healthcare. This had proved popular with patients, healthcare staff and prison staff as it improved patients' access to the GP.
- A database of patients who required care plans had been set up that supported monitoring and informed areas for audit. The trust managers had completed a care plan audit to monitor progress; however, the audit sample of 21 patients was limited. Managers acknowledged this and the need for ongoing monitoring.
- Care and treatment for patients with long-term health conditions remained effective, with regular clinics available to review patients and good oversight of the population by the lead nurse through use of a national framework. Those with long-term health conditions had regularly reviewed, person-centred care plans in place, and received appropriate input from specialist services. The provider was working to train more staff to support patients with long-term health conditions.
- Medicines optimisation services were in the early stages of implementation and needed embedding to ensure that all monitoring requirements were considered. The clinical director was working with the multidisciplinary team to ensure a streamlined and cohesive approach was taken to medicines prescribing. We saw examples of patients receiving a holistic approach to medicines use and medicines reviews were clearly recorded.
- A system had been implemented to ensure supplies of medicines were maintained with attention to high risk

medicines and those which could only be obtained from a consultant. This system meant that patients were identified earlier in the reception process so that they did not go without their medicines. This was an improvement from the previous inspection.

Effective staffing

At our last inspection, we found the uptake of some mandatory training was poor. Healthcare staff, including nurses, healthcare assistants, pharmacy technicians and social care support workers did not receive regular managerial or clinical supervision.

- During this focused inspection, we found staff continued to have protected time to complete mandatory training. Records demonstrated an improved uptake of mandatory training by staff, particularly in respect of safeguarding, basic life support, intermediate life support and the Mental Capacity Act 2005.
- The local arrangements for staff supervision had been developed since our 2018 inspection but were not yet fully embedded. Supervision was more effectively promoted and recorded to aid monitoring. A sample of five staff records showed that a supervision template and contract was in use and that supervision provided an opportunity to discuss individual's clinical competency. From December 2018 a monthly staff briefing had been implemented, to enable staff to attend group supervision. Dates for one to one supervision had also been offered to all staff but uptake was variable. Staff we spoke with had not all received supervision, most notably pharmacy staff due to a manager vacancy. They told us that preparation for annual appraisals had commenced.
- In the absence of a corporate system for monitoring supervision activity a local matrix had been developed, which included records of supervision, training and staff absence, but not staff appraisal. Managers had completed an audit of staff supervision for the period January to March 2019. This showed that the 24 eligible staff had completed an average of two supervision sessions; however, for individual staff this varied from no sessions to five. Up to 33 of the 56 sessions completed were group supervision. Responses to a staff survey were limited but identified that not all staff were engaged with, or valued supervision. In response to the audit and survey there were plans in place to investigate further to determine how to engage with staff more effectively. There was work in progress to develop the supervision skills of junior managers to increase supervision opportunities.

Coordinating care and treatment

At our last inspection, we found instances when poor communication did not support positive outcomes for patients, including those under the care and treatment of specialist.

- During this focused inspection, we found healthcare staff worked together and with other health and social care professionals effectively to deliver care and treatment. Care records showed that healthcare staff from different organisations, for example, GPs and mental health workers, had been involved in assessing, planning and delivering coordinated care and treatment.

Are services caring?

Kindness, respect and compassion

At our last inspection, we found that patients had a negative perception of their contact and experience of healthcare services.

- At this inspection patients told us that healthcare staff treated them respectfully when they attended clinics. Those receiving support with personal care were very complimentary about the help they received from care support staff.
- We observed positive and caring interactions between healthcare staff and patients.

Involvement in decisions about care and treatment

At our last inspection, we found that some clients in receipt of a social care support did not have a copy of their care plan, although some had declined to hold a copy. Some patients told us that healthcare staff did not always communicate the outcome of clinical investigations.

- During this focused inspection, we found that some prisoners in receipt of a social care support held a copy of their care plans; others told us they had declined a copy. These care plans detailed what social care service had been commissioned and how it was to be delivered, for example, assistance with personal care, including showering.
- Some prisoners told us that that healthcare staff still did not always explain their treatment clearly and they told us of long waits to receive the results of clinical investigations. Records we reviewed, particularly for prisoners with long-term health conditions, demonstrated appropriate interactions including discussions about treatment delivered.
- Nurse led care plans in relation to prisoners with long-term conditions, for example, diabetes, were stored electronically on a patient records system. We sampled these records and observed records were personalised and included evidence of patient involvement.
- Some patients managed their medicines using dosette boxes. These enabled patients to have more control and involvement in this aspect of their care and treatment.

Privacy and dignity

At our last inspection, we found that clinic room doors remained open during nurse-led consultations and patient confidentiality was compromised. Processes for informing prisoners of scheduled healthcare appointments did not ensure patient confidentiality.

- During this focused inspection, we found that healthcare staff no longer left clinic room doors open routinely during clinics and consultations. Prisoners told us that they could now have confidential conversations with healthcare staff in the healthcare centre and at wing treatment rooms, for example discussions about their prescribed medication.
- The process for informing prisoners of scheduled healthcare appointments now ensured patient confidentiality. Appointment slips were now routinely delivered to prisoners in a sealed envelope. Patients confirmed this process.
- The prison was piloting a new appointment system, where appointments and visits would be recorded on one electronic system to improve patients' experience.

Are services responsive to people's needs?

Responding to and meeting people's needs

At our last inspection, we found that patients waited too long before being seen in healthcare and in some instances were returned to wings without being seen and clinics were suspended. Nurses were not visiting the care and separation unit. It is a prison requirement that a member of healthcare staff must assess the physical, emotional and mental wellbeing of prisoners held in segregation daily.

- During this focused inspection we found prisoners' attendance at healthcare appointments continued to be monitored regularly and analysed. Non-attendance rates across primary care services were low. Healthcare staff worked closely with prison staff to ensure prisoners attended healthcare appointments. Prisoners who did not attend healthcare appointments were followed up by nurses to find out why they had not attended an appointment.
- The use of the healthcare appointments ledger had improved significantly, with most appointments now updated to reflect attendance and completion or cancellation. Healthcare staff took prompt action reviewing incoming tasks and blood test results with oversight and monitoring by healthcare managers.
- Nurses now visited prisoners held in the care and separation unit daily, and GPs reviewed prisoners at least three times per week, as required by the prison service to ensure the physical, emotional and mental wellbeing of prisoners located there. These interactions were recorded on a computer system and recorded in the prison wing log book. Prison officers reported that healthcare attendance in the segregation unit had improved since our last inspection.

Timely access to care and treatment

At our last inspection, we found that non-attendance rates were being monitored but data was not reliable.

- During this focused inspection, we found that the recording of failed appointments on computer systems had improved, and patients were routinely re-booked a further appointment when a clinic was cancelled for staffing reasons. Patients who did not attend health appointments were asked to book another appointment to reflect community practice. Those who were unable to attend for reasons outside of their control were automatically rebooked.
- Waiting times for most nurse-led and GP clinics were acceptable, and there was good access to emergency care. The provider was developing links with the gym to improve access to NHS health checks from June 2019.
- However, we observed that there were currently long waiting lists for vaccinations including hepatitis B, MMR and meningitis C. Only one nurse was currently able to administer vaccinations, but the trust had training planned to ensure that more staff could complete vaccinations by July 2019.
- During our last inspection waiting times for dental appointments were acceptable. At the time of this focused inspection records showed that the waiting time for dental appointments had increased to 18 weeks, which was far too long. However, the trust had identified this prior to our inspection and some actions were in progress to reduce the waiting time, including holding additional dental sessions to reduce the backlog.
- The dental waiting list had been reviewed to improve its accuracy, dental staff told us that further 'cleansing' was required. However, their capacity for administrative time was very limited and they said that they were unable to provide triage to aid prioritisation of appointments.
- Despite our concerns about how long patients waited to see the dentist, the rate of non-attendance at dental appointments was 14%, indicating that few appointments were wasted. Records showed that the dental team received a low number of complaints about the treatment they received, which suggested patient satisfaction. Once seen by the dentist, patients received assessment and treatment that was comparable to that available in the community.
- The trust was developing a Band 6 nurse to lead on sexual health support for patients, part of which included developing links with external specialists.
- Patients generally reported having prompt access to prescribed medication, including improved access to critical medication for life-long conditions. Some prisoners told us it was difficult to obtain paracetamol as this currently had to be prescribed by a clinician.

Are services well-led?

Leadership capacity and capability

At our last inspection, we found the trust was not sufficiently focused on staff development and/or service development, improvements were not sustained, and healthcare managers were not visible.

- During this focused inspection, we found that healthcare managers and the trust were sufficiently focused on staff development and service development and because of this improvements had begun to occur and were being sustained.
- Healthcare managers told us they were now able to dedicate more time to management tasks. Managers were not routinely involved in the delivery of physical care to patients.
- Some staff told us since the appointment of the director for health and justice and the acting head of operations, they felt better supported and listened to.
- On-call manager support to staff had improved. Staff meetings were more structured than previously with a set agenda. Staff told us they felt more able to contribute and were listened to.

Vision and strategy

At our last inspection, individual staff told us they felt that they received insufficient support from the wider trust. Induction arrangements for permanent and agency staff was not happening. The oversight and management of staff supervision was insufficient.

- During this inspection healthcare staff told us that healthcare managers were now more visible and supportive, with improved access to managerial supervision and regular staff meetings facilitated by managers. Staff felt that there were now clear processes and procedures in place to support their work. Staff reported that the service was more structured, which supported consistency of patient experience and had prompted complimentary feedback from prison staff.
- During this inspection we met with a focus group of 14 staff as well as speaking to individual staff as opportunities arose. The feedback we received from staff about the leadership and management of the service was overwhelmingly positive.
- Whilst vacancies remained, a stable group of agency staff were supporting the permanent team. Staff confirmed that staffing levels and available skill-mix were still variable, but due to the increasing cohesiveness of the team, reciprocal cover was more available than in 2018. Pharmacy staff felt that they were providing a more consistent presence on the residential units but lacked a degree of direction in the absence of a junior manager; however, recruitment to this post was well advanced.
- Induction for permanent and agency primary health care staff was now a priority and all new staff had a formal induction.

Culture of the organisation

At our last inspection, we found that incidents were not routinely reported, for example, daily tests of equipment and fridge temperatures. Individual staff told us they didn't feel listened to and involved in the day to day management of the service. Staff spoke of feeling undervalued and not appreciated.

- During this focused inspection, we found that positive changes to the way the service was delivered were evident and staff confirmed that these were communicated clearly to them through daily meetings, which were recorded. Staff we spoke with told us they could raise concerns and were encouraged to do so.
- Healthcare staff were better supported to have a stronger voice across the organisation.

Governance arrangements

At our last inspection, we found systems and processes to support good governance and management of the service were limited at local level, for example, staff meetings did not take place on a regular basis. Learning from incidents did not routinely happen. The uptake of mandatory training was not monitored and checks of emergency equipment was not happening.

- During this focused inspection, healthcare managers and staff told us that communication and information sharing with the prison had improved since the appointment of a healthcare governor.
- We found that systems and processes for learning and continuous improvement were firmly embedded across the service and learning from events was promoted, shared and used to make improvements. Healthcare staff received feedback from incident reports they submitted and there were now better opportunities for staff to learn from events and improve outcomes for patients

Are services well-led?

- Systems and processes providing all staff with the development they needed, including supervision had been developed but more time was needed to assess the full impact of the changes
- Mandatory training was closely monitored by healthcare managers and the uptake by staff had improved. Mandatory training was mainly completed online and actively monitored. We received mixed staff views about access to training, citing technological issues and some inequity of access to non-mandatory training opportunities.
- Healthcare staff completed regular checks of emergency equipment bags and managerial governance checks were undertaken to ensure that equipment was monitored and fit for purpose. This meant that the safety of patients was protected.

Managing risks, issues and performance

At our last inspection, we found processes for managing risks and performance were not fully effective. Monitoring systems did not support processes to identify, understand and address risks, including risks to patient safety. There was limited evidence of management oversight or monitoring, for example, cancelled primary health care clinics.

- During this focused inspection, we found that processes for managing risks and performance had improved and were now effective. Healthcare managers had effective oversight of several key areas, including the continuation of medicines and ensuring healthcare staff had completed mandatory training.
- The trust risk register identified several risk areas, including the need for more staff to be trained in administering immunisation and vaccination programmes. The risk register was reviewed regularly and updated monthly. All risks were reviewed by the director for health and justice services and at the risk council and could be escalated to the quality and safety committee when necessary. This provided oversight of risks at board level.
- The introduction of a health and justice weekly patient safety meeting was a new initiative since our last inspection in July 2018 and provided an opportunity for discussion of incidents, formal complaints and actions to address concerns
- A range of monitoring systems undertaken by healthcare staff identified risks to patient safety and supported and identified actions to address risks, for example, care plan audits and In-possession risk assessments audits.

Engagement with patients, the public, staff and external partners

At our last inspection, we found engagement with patients was not a priority.

- During this focused inspection we found that healthcare service user forums were held monthly. The meetings were attended by prisoners, healthcare staff from primary health and mental health services, representatives from the Independent Monitoring Board and the healthcare governor.
- The meetings were used to exchange and share information including updates and progress on issues that prisoners had raised at a previous meeting. Prisoners who attended the monthly patient forum reported good communication from healthcare managers about service developments and improvements.
- Minutes we reviewed from the healthcare service user forum demonstrated effective engagement with patients, internal and external partners.

Continuous improvement and innovation

At our last inspection, we found learning from reported incidents was not effective or sufficiently embedded across primary health care services. Handover meetings lacked structure and there was an absence of the use of audits to develop the service.

- During this focused inspection, we found systems for recording and responding to significant events were fully in place. Reporting systems were fully established at local level and trust level.
- The introduction of bi-monthly health and justice bulletins was an effective means of sharing information about key developments in the service and plans for the service.
- Handover meetings were better managed and well attended. Changes to the way the service was delivered were evident and staff confirmed that these were communicated clearly to them through daily meetings, which were recorded.

Are services well-led?

- At this inspection we found that clinics were rarely cancelled, which was a significant improvement on our findings in 2018. Other indicators of improvement were a reduction in complaints from patients, particularly about the availability of their prescribed medicines.