HMP Winchester

Inspection report

Romsey Road
Winchester
SO22 5DF
Tel: 01962723000

Date of inspection visit: 14, 15, 16 November 2022
Date of publication: 06/02/2023

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.

Ratings

Overall rating for this location	Inspected but not rated
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Overall summary

We carried out an announced follow up inspection of healthcare services provided by Practice Plus Group Health & Rehabilitation Services Limited (PPG) at HMP Winchester on 14 to 16 November 2022. This was in response to a HMP comprehensive inspection carried out in January/February 2022 when we found the quality of care required improvement. We issued two Requirement Notices in relation to Regulation 17: Good governance; and Regulation 18: Staffing.

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

At this inspection we found the required improvements had been made and the provider was meeting the regulations.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection we found:

- Systems and processes to ensure that onward referrals were made and tracked following the identification of mental health needs had been introduced.
- Systems aimed to ensure patients were monitored and received care and treatment in line with presenting risks.
- Processes to ensure the effective sharing of patient risks had been strengthened.
- Staff vacancies remained a challenge in the delivery of care of treatment. New systems, however, had been implemented to ensure tasks were prioritised effectively.
- Many, but not all staff, received managerial and clinical supervision in line with company policy.
- A new Practice Plus Group supervision tool had been introduced to improve quality and consistency in its delivery.
- Staff felt supported and were able to access supervision forums.
- A system to record and monitor supervision had recently been introduced.

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

- The provider should ensure that all staff receive clinical and managerial supervision in line with company policy.
- The provider should ensure that all eligible staff who undertake the role of early days in custody practitioner are upskilled in triage and revised systems and processes.

Our inspection team

Our inspection team was led by a CQC health and justice inspector supported by one HMIP inspector.

How we carried out this inspection

We conducted a range of interviews with staff and reviewed a range of information that we held about the service including notifications. During the inspection we spoke with staff including:

- Head of healthcare
- Deputy head of healthcare
- Primary care lead
- Primary care nurses
- Health care assistants
- Dentist
- Senior pharmacy technician
- Prison officers
- Prison health care governor
- GP

We also spoke with NHS England and NHS Improvement (NHSEI) commissioners and requested their feedback prior to the inspection. We spoke with patients across the prison, observed medicines administration, and accessed patient clinical records during our onsite visit on 14 to 16 November 2022.

We asked the provider to share a range of evidence with us. Documents we reviewed included:

- Mandatory training compliance
- Staff supervision compliance data, including policy and supervision toolkit
- Risk register
- Information relating to the staffing model, vacancies and recruitment
- Number of cancelled hospital escorts
- Clinic information, including cancelled clinic data
- Medicines on release and transfer data April to October 2022
- Senior leadership team meeting minutes
- Healthcare daily shift planner

Background to HMP Winchester

HMP Winchester is a small Victorian reception prison that serves the courts in south and central England. At the time of this inspection it held 630 prisoners in the main category B prison and a small, separate category C facility. Over half of all prisoners were unsentenced and nearly 90% had been at Winchester for 3 months or less. The prison is operated by His Majesty's Prison and Probation Service.

Practice Plus Group Health & Rehabilitation Services Limited (PPG) is the prime provider of health care at HMP Winchester, including mental health and substance misuse services, with subcontracted services including Time for Teeth, which provided dental care.

PPG is registered to provide the following regulated activities at the location: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

Our previous comprehensive inspection was conducted jointly with HM Inspectorate of Prisons (HMIP) in January/ February 2022 and published on the HMIP website on 25 May 2022. We found a breach of Regulation 17, Good governance; and a breach of Regulation 18, Staffing. The report can be found through the following link:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/05/Winchester-web-2022-1.pdf

Inspected but not rated

Are services effective?

We did not look at all aspects of this key question during this focused inspection.

Effective needs assessment, care and treatment

During the January/February comprehensive HMIP inspection, systems and processes were not always effective in ensuring onward referrals were made as required following the identification of need within the reception screening. Managers did not monitor or review the list of referrals to ensure all needs were addressed, and reception referrals to the mental health team were not always followed up. This meant new patients arriving into the prison with identified needs were not always seen promptly.

During this focused follow up inspection, we found significant progress where systems and processes had been reviewed and new procedures had been implemented with the aim of ensuring patients were seen promptly in line with their assessed level of need.

In particular, we found that:

- Patients with mental health needs identified during the initial reception healthcare screening process were added to a newly implemented referral 'tracker'. This provided assurance in addition to the electronic patient record system in the monitoring of patients' progress from the point of reception to treatment. The tracker also supported with the monitoring of patients awaiting hospital transfer, those receiving depot injections (A depot injection is a slow-release form of medication), and patients being managed under the care programme approach.
- Each morning, an 'early days in custody' practitioner reviewed a list of all new receptions who had arrived at the prison the previous day. A mental health triage was completed for all patients within 48 hours, or earlier, where significant risk had been identified, with routine referrals being triaged within 5 working days. Whilst performance had dropped during September 2022 due to staffing challenges, in October 2022 100% of new receptions had received a triage assessment by an appropriately trained practitioner within these timeframes.
- The mental health team's performance was monitored through a monthly dashboard and a 'near live' report enabled timely oversight and corrective action to be taken should urgent or routine referrals not be seen within agreed timeframes. Staff told us they were aware of the performance data, with one member of staff reporting there were now "progressive, shared action plans". Nevertheless, whilst many staff spoke positively of the new systems, they reported that staffing challenges remained a concern. Some staff told us that much of their work was crisis-driven, and that the provision of therapeutic work was a challenge due to staff vacancies and the high turnover of patients at the prison.
- The shift allocation sheet had been improved which set out staff ownership of core duties whilst the clinic ledgers had been revised to reflect priority activity for each day. The systems aimed to improve effectiveness in the delivery of care and treatment and ensure patients with identified mental health needs were addressed.
- The mental health team handovers had increased to twice daily with a representative in attendance at a daily integrated staff handover meeting to ensure the effective sharing of information. Patients of concern, or those with immediate presenting risks, were escalated for oversight through the correct pathways such as the multi professional complex case clinic.
- Whilst much progress had been made to improve performance, systems had recently been introduced at the time of our inspection. Further work was required to develop and embed processes, such as the referral tracker and roll out of the rotation of the early days in custody practitioner role and refresher triage training.

Effective staffing

At our previous HMIP comprehensive inspection, staff access to clinical and managerial supervision was inconsistent: The provision and uptake of clinical and managerial supervision was not delivered in line with the organisation's supervision policy. Staff we spoke with said they had not received regular supervision.

Inspected but not rated

Are services effective?

Since the previous inspection we found progress in that many, but not all, staff received regular clinical and managerial supervision. In particular, we found:

- There had been significant change in the leadership team with the recruitment of a new head of healthcare, deputy head of healthcare, primary care lead, and business manager. Feedback from staff was positive regarding improved consistency in the leadership team and strong leadership from the head of healthcare.
- A review of the healthcare service had been undertaken with the aim of driving improvements in the provision of safe and effective patient care, whilst also embedding a culture of continuous learning across the team. The model of service delivery, the workforce, and the provider's financial position had been considered, whilst staff wellbeing had remained a key priority.
- A review of leadership roles and responsibilities provided staff with greater clarity of the line management structure, enabling support and knowledge to be accessed more readily.
- An integrated team approach to shared learning had been further developed with a 'lock down' afternoon each week set aside for wellbeing, one to one's, reflective practice, and the completion of training. Compliance with mandatory training was 89% which was good. 'Hot' debriefs following incidents enabled timely support and learning to be shared across the team whilst staff handover meetings had increased from 2 to 3 a day to drive up quality through the effective sharing of knowledge and information.
- Staff now had access to a PPG national practice nurse educator for supervision, and a qualified nurse advocate was in post with a further two members of staff in training to support staff in their roles.
- A psychologist had facilitated a supervision awareness day in May 2022 and offered regular clinical supervision to staff within the mental health team. One staff member told us that this had been a 'huge support' and provided the required space for 'clinical thinking'.
- The PPG national supervision project had recently been introduced at HMP Winchester; this aimed to enhance support for the wellbeing of staff by embedding a culture that promoted the value of regular and accessible high-quality clinical supervision. At the time of our inspection, the toolkits had been shared with the team and plans were in place for their use in future one to one sessions. A new 'tracker' aimed to ensure effective monitoring of supervision compliance.
- Whilst many staff had begun to receive regular managerial and clinical supervision which represented significant improvement since our previous inspection, there remained gaps where some staff had not received supervision in line with policy. Action plans were in place to progress performance following the roll out of the PPG national supervision project and work continued, one leader told us, to ensure this would be 'meaningful' for staff.
- The service had continued to experience recruitment difficulties and, at the time of our inspection, a number of vacancies remained unfilled across the service. The staffing situation was not dissimilar to that found during the January/February 2022 inspection, and gaps across the service continued to present a challenge in the planning and delivery of treatment and care to patients. A core group of bank staff often filled vacant shifts whilst the provider continued to advertise vacant positions such as for the mental health lead, registered mental health nurses, a pharmacist, and pharmacy technicians.
- Following the service review, a new rota had been developed to reduce the risk of gaps arising in service provision and to ensure there was an effective system in place to plan over a 3-month period. Whilst staffing levels were generally at the minimum requirement, on occasions where staffing levels dropped managers ensured core and essential services, such as medicines administration, were maintained.

Inspected but not rated

Are services well-led?

We did not look at all aspects of this key question during this focused inspection.

Leadership capacity and capability

Since the last HMIP comprehensive inspection there had been change in management and leadership at HMP Winchester. A new head of healthcare, deputy head of healthcare, primary care lead, and business manager had been appointed. We found that:

- Staff were positive about the leadership team and felt that the improvements had been driven by strong leadership and an improved, open culture.
- Staff we spoke with provided positive feedback about the head of healthcare reporting they were 'proactive', 'driven' and 'very impressive'.
- Leaders were clearly visible to staff around the site and it was apparent that they knew staff well.
- Leaders recognised the team were 'on a journey' and had engaged with staff in the service review and action plans to take a joint response to initiating service improvements.

Governance arrangements

At our last inspection we also found that the provider's systems were not always effective in ensuring onward referrals were made following the identification of need within the reception screening. Managers did not monitor or review the list of referrals to ensure all needs were addressed, and reception referrals to the mental health team were not always followed up.

During this inspection we found that:

- New systems had processes had been introduced that aimed to ensure all patients with an identified mental health need were systematically tracked from referral through to treatment and beyond.
- Some systems and processes required further development and embedding to ensure they were continuously effective in the management of patients with mental health needs.

At our last inspection we also found that the provider's systems to ensure staff received managerial and clinical supervision in line with policy were not effective.

At this inspection, we found that:

- Staff reported they were well supported by managers and felt there was a strong leadership team in place.
- Staff were able to access a variety of supervision approaches including clinical group supervision, management supervision, and multi-disciplinary team meetings. An action plan was in place to embed the new PPG national supervision tool and ensure all staff received supervision in line with the provider' policy.