HMP Garth

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.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out an announced comprehensive inspection of healthcare services provided by Greater Manchester Mental Health (GMMH) NHS Foundation Trust between 6 and 8 September 2023.

The purpose of this comprehensive inspection was to determine if the healthcare services provided by GMMH were meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that patients were receiving safe care and treatment. This inspection included follow up of the Requirement Notice we issued after our inspection in November 2022. This related to issues we found with medicines management practices. Details can be found at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2023/03/Garth-web-2022.pdf

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:

- Healthcare staff worked diligently and flexibly to provide safe and effective care in challenging circumstances associated with the prison regime and culture.
- The provider had made significant improvements to medicines management practices.
- The provider had a wide range of skilled staff across all services who were suitably qualified and experienced for their roles. Staff reported good team working and mutual support.
- Staff treated patients with dignity and respect. Staff completed timely assessments of patients' needs and risks and planned appropriate care and treatment.
- Examples of good practice included the neurodevelopmental pathway, the range of groups offered by the drug and alcohol recovery service, the social care pathway and tracker, the flexible, timely access to the substance misuse prescriber, and the lessons learned bulletin.

However, we also found:

- Some issues with medicines management had not been fully resolved, and we also identified new concerns.
- There were staffing shortages across healthcare with the primary care team being the most stretched.
- There were delays in collecting and responding to complaints, and the quality of responses varied. The spreadsheet for managing external appointments was not up to date.
- There was a lack of accurate data on daily staffing deficits and cancelled clinics, which made it difficult to assess the extent of the issues faced by the service. Audits did not always identify issues or result in effective improvements.

We found two breaches of regulations. The provider **must**:

- Ensure the proper and safe management of medicines (Regulation 12 (1))
- Ensure good governance through effective systems and processes (Regulation 17 (1)).

In addition to the breaches, the provider **should**:

- Improve staffing levels, especially in primary care.
- Address the back logs for activities such as 13-week reviews and routine drugs testing for people on opioid substitution treatment, and annual health checks for people on the Care Programme Approach.
- Offer specialist training in substance misuse to all staff involved in any substance misuse care.
- Cleanse data and keep records such as waiting lists, tasks and reviews updated.
- Review and personalise care plans for patients with long-term conditions.

Overall summary

- Review policies that are overdue for review or out of date.
- Continue to work with the prison to address the inequitable access to healthcare for patients on E, F and G wings.
- Continue to work with the prison to improve medicines administration, especially at the points for A and B, and C and D wings.

Our inspection team

This inspection was carried out by two CQC health and justice inspectors and a CQC pharmacist specialist.

How we carried out this inspection

Before the inspection, we reviewed a range of information and data that we held about the service and information sent to us by the provider and commissioner. We also reviewed some patient records via remote access to the electronic records system.

During the on-site inspection, we looked at the quality of the healthcare environment and facilities, and at systems and processes relating to the running the service. We reviewed medicines management practices and looked at patients' care and treatment records. We spoke with a range of staff in healthcare including the head of healthcare and other senior managers, nurses, pharmacy staff, GP, administrative staff, and specialist practitioners.

Background to HMP Garth

HMP Garth is operated by HM Prison Service and is a Category B training prison near Leyland, Lancashire for up to 845 men.

HMP Garth is situated next to another prison with which it has some shared working arrangements.

Greater Manchester Mental Health NHS Foundation Trust (GMMH) is commissioned by NHS England to provide primary health care, mental health services, substance misuse services and social care at HMP Garth. GMMH subcontracts Delphi Medical Limited to provide psychosocial recovery interventions.

GMMH is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Inspected but not rated

Are services safe?

Safe and clean environment

- The areas used by healthcare were visibly clean, and in reasonable condition. The provider had identified the need for repairs to walls, floors and ceilings and informed the prison who was responsible for the condition of the environment.

Safe staffing

- The service experienced staffing pressures across most service areas with the primary care team being the most stretched. Staff from all service areas spent a significant amount of time on medicines administration, which affected their ability to plan and provide other healthcare activities such as clinics and one-to-one interventions. Some functions did not have designated leads, for example, health promotion and sexual health.
- The primary care team had a vacancy rate of 42%, which equated to 11 vacant roles. The provider used regular agency staff to increase staffing numbers. However, we found it difficult to determine the frequency of staffing shortages because managers did not record daily deficits on the rota, and the trust had not set a minimum safe staffing level.
- The service ran an integrated mental health and substance misuse team led by one team manager, which was quite a demanding role given the demand in each service. The mental health team showed an improving staffing picture with several vacancies recruited to. However, the team expressed the need for a dedicated lead for complex cases and a healthcare assistant to support clinics.
- The clinical substance misuse service had very few substantive staff and relied on bank and agency staff. They were clearly stretched with large caseloads, and back logs for some key activities. Demand on the team was high due to the numbers of patients on detoxification treatment and the scale of illicit drug use in the prison.
- The clinical substance misuse service had access to an interim non-medical prescriber shared between HMP Garth and the neighbouring prison. The prescriber was available on site one day a week and remotely on another day, with flexibility to meet any urgent requests.
- The drug and alcohol recovery team had most of their staff team in place, with only one vacancy, and were able to provide a comprehensive range of interventions based on patients' needs.
- The administration team had significant vacancies, with some staff working across both HMP Garth and its neighbouring prison. This affected the capacity available to oversee complex functions such as managing the external appointments tracker.

Assessing and managing risk to patients

- Staff completed comprehensive reception screenings with newly arrived prisoners. They identified any immediate needs and risks and made onward referrals to other health professionals, where appropriate.
- Patients received timely assessment of their physical health, mental health, substance misuse and social care needs. The service offered a range of scheduled clinics, which had reasonable waiting lists with emergency and duty systems in place to respond to immediate risks and urgent needs.
- The primary care service had a long-term conditions (LTC) pathway led by skilled staff, and patients had access to regular clinics. The clinical substance misuse team and the drug and alcohol recovery team worked together to provide a coordinated care pathway. Mental health team staff undertook reviews of people in segregation and supported the prison with prisoners subject to 'ACCT' (Assessment, Care in Custody and Teamwork). This is the care planning framework for prisoners identified as being at risk of suicide or self-harm.

Staff access to essential information

Inspected but not rated

Are services safe?

- The service used an electronic system for recording and managing patient information. Patients' records were kept secure as the system could only be accessed by authorised staff using a 'smartcard'. Staff were aware of the need to maintain patient confidentiality when liaising with the wider prison staff.
- Staff kept patients' care records in good order and up to date. Patients' notes were comprehensive containing the appropriate assessments, care plans and reviews. All healthcare staff, including agency staff, had access to the system.
- The service used an electronic system for scheduling clinics and appointments and maintaining waiting lists. However, some waiting lists needed review as we found repeated tasks, overdue reviews, and patients' names not removed after their appointments.
- Although staff identified people with conditions that met an NHS Quality Outcomes Framework (QOF) domain, the provider acknowledged the need for review and cleansing of the QOF data they held to give an accurate picture of need.

Medicines management

- At our last inspection in November 2022, we identified a number of concerns with the management of medicines and issued a Requirement Notice. At this inspection, we found that improvements had been made in most of the areas. However, some issues remained and we also identified some new concerns.
- At our last inspection, we found that pharmacy services did not have enough trained and competent staff to deliver the safe and proper management of medicines across the site. At this inspection, we found that pharmacy staffing had improved but it remained challenging for staff to complete all the required tasks. For example, in August 2023, staff completed only 50% of medicines reconciliation checks within 72 hours.
- At our last inspection, medicines compact agreements were not present in some patients' reception records. At this inspection, we sampled 12 records, 4 had local compact agreements missing. The healthcare manager had plans to improve this practice.
- At our last inspection, we found that deliveries of medicines were unsafe and not risk assessed. At this inspection, we found that the delivery process had improved and risk assessments were in place.
- At our last inspection, there was no Methasoft machine to administer methadone for F and G wings so staff had other arrangements in place, which did not have sufficient risk mitigation. At this inspection, the provider had installed a Methasoft machine for F and G wings.
- At our last inspection, controlled drugs books on E and F/G wings were not completed appropriately. At this inspection, we found that controlled drugs were administered appropriately although errors continued to be reported. There was an action plan in place to reduce errors by 30% by November 2023.
- At our last inspection, we found oxygen cylinders in the downstairs storage room that were not securely stored and there was no signage present indicating the presence of oxygen. At this inspection, these issues had been resolved.
- At our last inspection, we found that not all healthcare staff had signed up to the homely remedies policy to guide them. At this inspection, this had been resolved.
- At our last inspection, we found that governance arrangements were not sufficiently robust to ensure safe and effective oversight of medicines management and prescribing practice. At this inspection, the service held monthly medicines management meetings that were well attended, and there were medicines safety meetings across five prisons that reviewed incidents and shared learning.
- At this inspection, we found that the service used systems and processes to safely prescribe and store medicines, however, administration and recording was not always accurate, and it was not possible to ascertain whether prisoners had always received their prescribed medicines. We found numerous occasions where administration records were left blank or had limited details recorded so it was unclear if and why prisoners had missed their medicines.
- Staff administered medicines from 4 medicines administration points (MAPs) located either on the wing or in corridor hatches twice a day. We observed 2 medicines administration sessions that took place in corridor hatches for A and B

wings and C and D wings. Although prison officers were present to assist staff during administration of medicines, we witnessed challenging situations for healthcare staff where queues were disorderly, the noise levels were high, and there were lots of disruptions by prisoners. Furthermore, the need to administer opioid substitution treatment (OST) at morning sessions, and the distribution of large amounts of 'in possession' medicines at afternoon sessions contributed to the lengthy medicines administration rounds (up to 3.5 hours) and increased the risk of errors. The provider had offered many ideas and solutions to the prison to improve safety and reduce the time taken but this required reliable and effective enablement from the prison, which was not always available.

- Staff used a secure trolley to administer medicines on the segregation wing. Staff had a safe protocol that covered the arrangements for transporting medicines such as methadone to the segregation unit.
- Staff completed medicine reviews although these were not always recorded consistently on the electronic system. The service had developed a new template to improve this.
- Pharmacy technicians conducted spot checks on medicines 'in possession'. These are individually prescribed medicines that are issued to patients to manage themselves.
- Pharmacy staff were involved in multi-disciplinary reviews and participated in daily huddles where any safety concerns could be raised. The non-medical prescriber for the clinical substance misuse team offered OST reviews on request and routinely every 6 months.
- Patient group directions (PGDs) were available to allow nurses to administer medicines to prisoners without a prescription. Emergency medicines were available for use and emergency bags were checked regularly. Homely remedies were available for prisoners to access for the treatment of minor ailments.
- Staff had received medicines management training, and all had current competencies in place.

Track record on safety

- During our inspection, we found that healthcare services were operating in an unsafe and volatile environment due to the lack of sufficient order and discipline in the prison. The prison had ceased wing-based service provision due to the heightened security level. However, we observed staff working in challenging circumstances especially during medicines administration. The provider had recognised the risks to staff and the impact on their ability to provide safe and effective healthcare and had submitted a report to the prison governor. The provider had also advised staff to cease activities if the situation became disruptive and unsafe and to request urgent assistance.
- Due to the high levels of illicit drug use and associated incidents at the prison in the past year, the service had experienced a huge demand for emergency and urgent responses. Therefore, staff had reviewed and improved some processes. For example, staff carried extra Naloxone in the emergency bag; emergency bags were packed with easiest access to the most used items; and staff carried respiratory masks to prevent inhalation of illicit drugs.

Reporting incidents and learning from when things go wrong

- Staff recognised incidents and reported them appropriately on the trust's electronic incident reporting system.
- The provider had a clear and structured process for investigating incidents. Managers investigated incidents and identified lessons learned. Incident management included oversight and input from the trust's senior management team, where appropriate.
- The provider shared lessons learned with the whole team through a range of mechanisms including team meetings, briefings, and bulletins. These included updates from clinical reviews and death in custody recommendations.

Inspected but not rated

Are services effective?

Assessment of needs and planning of care

- New prisoners received comprehensive primary and secondary screenings, followed by further assessments if needed by the relevant specialism.
- Patients had care plans that showed their needs and the treatment and care they required. However, in our review of 10 care plans of patients with long-term conditions, we found that they were not personalised and not always reviewed regularly.
- Staff could not always offer appointments and clinics as planned due to issues with the prison regime and the time taken on priority activities such as medicines administration. Staff worked flexibly and spontaneously making good use of any time available to see patients.
- The mental health team triaged referrals based on urgency, completed initial assessments and then discussed them at weekly single point of access meetings to agree the appropriate care and treatment pathway.
- The learning disability and neurodiversity nurse attended monthly reasonable adjustments panels with the prison to discuss people with learning disabilities or neurodiversity who had specific needs.

Best practice in treatment and care

- Staff provided a range of treatment and care for patients based on national guidance and best practice. However, staff vacancies and pressures in the prison meant the provider had to prioritise key functions. For example, health promotion was limited because the service did not have a health promotion lead.
- The primary care service offered a range of health checks including blood-borne virus screening, testing and referral; chlamydia screening; age-related screening programmes such as for abdominal aortic aneurysm and bowel cancer; retinal screening and diabetic foot checks.
- Staff offered age-appropriate immunisations and vaccinations, and planning was underway for the seasonal 'flu and COVID-19 vaccination programmes. Staff provided smoking cessation advice on an individual basis and hoped to offer vaping cessation in the future.
- The service had an end-of-life care pathway and a local dementia care pathway. Senior nurses led on care for older patients. They assessed falls risks and cognitive function, and made referrals to adult social care services, where appropriate.
- At the time of our inspection, 80 patients received opioid substitution treatment (OST). They received close monitoring in the early days of their treatment and 13 weeks reviews thereafter. Reviews were completed jointly by the clinical and drug and alcohol recovery services (DARS). At the time of our inspection, the service had a back log of patients needing 13-week reviews that the team had plans to address.
- Most patients on OST received methadone but a few received buprenorphine-based tablets. The service was reluctant to offer a full choice of treatments due to the high level of illicit drug use in the prison and the risk of diversion. The service was planning to offer prolonged release buprenorphine injections in the future.
- DARS had a caseload of 230 people in total. The service provided a wide range of groups and 1-1 interventions that supported people's treatment and recovery. These included alcohol awareness, family work and relationships, budgeting, creative therapy, impulsive behaviour, relapse prevention, self-help, cooking, acupuncture, managing anxiety, overcomers' programme, motivation, and prescription medicines awareness. However, attendance for patients on OST was voluntary as they were not required to attend recovery interventions as a condition of their treatment, which was not in line with the relevant national clinical guidelines.
- The mental health service operated a stepped model of care but at the time of our inspection, did not offer the full range of treatments and therapies. GPs offered pharmaceutical treatments and staff provided self-help information on prisoners' in-cell laptops. A small team of wellbeing practitioners offered low-intensity interventions on a 1-1 basis such as sleep hygiene, anger management, anxiety, depression, and eating healthily. A psychologist offered EMDR (Eye Movement Desensitisation and Reprocessing).

Inspected but not rated

Are services effective?

- The service was developing a range of talking therapies (also known as IAPTs) to be led by a soon to be qualified psychological wellbeing practitioner. There were no group sessions running but groups on cognitive restructuring and dialectical behaviour therapy were in the planning stage. A separate service (Manchester Survivors) was commissioned by the NHS to provide 1-1 intensive trauma-informed therapies.
- A psychiatrist and mental health nurses oversaw the care and treatment of patients with severe mental illness. They maintained a caseload of complex patients subject to the Care Programme Approach (CPA).
- The service had a well-developed learning disability and neurodiversity pathway supported by a dedicated lead nurse onsite and a regional neurodiversity strategy. This had helped ensure that people with learning disabilities and neurodiverse needs were identified and supported appropriately.
- Staff used the nationally recognised tools for their specialisms to assess needs and risk, plan care, monitor health, and complete observations. For example, primary care used the National Early Warning Scores (NEWS2), the substance misuse service used the Clinical Opiate Withdrawal Symptoms scale (COWS) and the mental health team used the Standard Tool for Assessment of Risk (STAR). The learning disability nurse had access to a range of assessment and diagnostic tools that included the Wechsler Adult Intelligence Scale (WAIS), Adaptive Behaviour Assessment System (ABAS) and the Autism Spectrum Quotient (AQ).

Skilled staff to deliver care

- The service had a range of suitably qualified and experienced staff to support effective treatment and care. The staff group included GPs, pharmacists, psychiatrists, nurses, psychologists, wellbeing practitioners and healthcare support workers.
- Staff received an appropriate induction and completed a comprehensive mandatory training programme. Service managers monitored compliance and gave staff time to complete their training.
- The clinical substance misuse service had access to an interim non-medical prescriber who had completed RCGP Certificate in the Drug Misuse Part 1 and Part 2. However, at the time of our inspection, no other staff had completed any specialist training in substance misuse even though many staff supported activities such as OST administration. The service manager advised us that Part 1 training had been arranged for one substantive member of staff in the clinical substance misuse team.
- The service had an integrated mental health and substance misuse service, which presented some challenges as not all staff felt confident working across both disciplines.
- The provider subcontracted a psychosocial recovery service to provide non-clinical, 1-1 and group interventions for people with drug and alcohol problems (DARS). DARS had a team of skilled and experienced care coordinators, recovery practitioners and support workers supported by a service manager and administrative staff.
- The service had a dedicated learning disability and neurodiversity nurse who was able to undertake assessments and diagnoses.
- Staff received regular clinical and managerial supervision and had access to team meetings and reflective practice sessions. In addition, the provider has set up a forum for general nurses across the prison cluster. Mental health team staff had access to group formulation meetings. Staff received annual appraisals.
- The provider offered training that would meet the needs of the service, fill gaps and vacancies, enhance skills, and improve recruitment and retention. For example, some staff had completed training in spirometry and oncology. The provider offered access to training to become a nurse, associate nurse, psychological wellbeing practitioner, non-medical prescriber, and advanced nurse practitioner. Staff welcomed the opportunities available but them but some said they struggled to access them due to staffing pressures and service priorities.

Multidisciplinary and interagency teamwork

Inspected but not rated

Are services effective?

- Healthcare relied on the support of the prison to operate a safe and effective service and had good working relationships with the prison governor and health link governor. Even so, enablement was not always available and the prison regime often had a detrimental impact on healthcare.
- The service had a range of effective multi-disciplinary meetings, for example, daily handovers, complex cases, 'under the influence', and single point of access (SPOA). These were well attended with contributions from all specialisms. Staff shared concerns about patients as well as other risks related to the prison environment. At the SPOA meeting, staff discussed how people's assessed needs could be met, and alternative options if there were waiting lists.
- DARS and the clinical SMS team attended each other's team meetings, which helped ensure joint working and information sharing. Staff supported the prison's drug strategy, which included prompt follow up of prisoners who had used illicit drugs.
- The service maintained good links and communication with local hospitals in order to manage external referrals and appointments effectively. The service had good working relationships with the local authority's adult social care division, which had a dedicated prison social care team.
- The service invited other agencies and providers to help them where appropriate. For example, primary care had made links with community providers of sexual health education and pulmonary rehabilitation services. The mental health team had arranged for the Alzheimer's Society to support their dementia pathway. DARS had arranged for an alcohol support group to provide sessions in the prison due to start in the near future.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Patients requiring assessment and transfer under the Mental Health Act (MHA) received appropriate assessment and timely transfer to inpatient psychiatric care. This included people with learning disabilities or neurodiverse conditions whose needs could not be met in a prison setting.
- At the time of our inspection, there were no patients awaiting transfer to a psychiatric hospital but there were two patients undergoing 'gatekeeping' assessments.
- Three patients had transferred to hospital under the MHA in the six months to 31 August 2023. The transfers were completed in line with national guidance.

Good practice in applying the Mental Capacity Act

- Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and the principles that underpinned it.
- Staff understood the need to seek consent from patients when providing healthcare. Staff supported patients to make their own decisions.
- Staff discussed any concerns they had about a patient's capacity and noted them in patients' care records. Staff completed cognitive function tests where necessary.
- The service had good links with the local authority and were aware they could raise any concerns about people's capacity for further assessment and intervention.

Inspected but not rated

Are services caring?

Kindness, privacy, dignity, respect, compassion and support

- We observed respectful interactions between staff and patients. Staff knew their patients well and were attentive to their needs.
- Staff followed up patients they had concerns about. For example, in one case, a staff member had taken the time to unpick a complex case involving the transfer of a prisoner with a serious long-term condition.

Involvement in care

- The healthcare service actively encouraged patients to engage with healthcare, for example, staff ran a wellbeing focus group in March 2023 to obtain ideas and suggestions to encourage prisoner engagement with wellbeing sessions.
- Healthcare staff attended the prison-led monthly patient forum, however, due to staff absence, the last forum took place in February 2023. Plans were in place to restart the forums from October 2023. Managers attended the prison council and welcomed feedback on health care and shared information on health.
- Staff encouraged self-care and independence. For example, many prisoners received their prescribed medicines 'in-possession', which meant they ordered, collected, and managed their own medication.
- The healthcare service could no longer distribute paper surveys due to the prison's ban on paper. The service worked with the prison to develop electronic patient surveys to be sent out monthly to prisoners' in-cell lap top devices and had recently sent out surveys on mental health and non-attendance at appointments.
- Mental health and substance use services regularly invited feedback from patients during one-to-one and group sessions.
- The drug and alcohol recovery service had around 18 recovery peers who supported patients on the drug recovery unit, and co-facilitated groups and activities. They were trained, supervised and supported by the team managers and dedicated staff.

Inspected but not rated

Are services responsive to people's needs?

Access and discharge

- The service faced daily challenges in providing healthcare activities due to the prison regime. However, staff worked flexibly to meet people's needs.
- All services had clear access criteria and accepted referrals from a range of sources including self-referrals. Waiting lists were minimal for the provider's services, primary care offered a 24-hour emergency response service, and there were good arrangements for urgent access to other services.
- The service experienced frequent ('no access') cancellations and high levels of non-attendance at appointments. We found that 31% of (643) GP appointments were not attended by patients in the 6 months to August 2023. In the same period, 47% of secondary care (external) appointments were cancelled by the prison. The cancellations disproportionately affected prisoners on E, F and G wings accounting for 43% of appointments that did not go ahead.
- Clinical staff from all service areas were needed regularly to supported medicines rounds, which were busy and lengthy. This affected the availability of staff for clinics and other interventions each day at the prison, which meant that not all patients could be seen as planned or scheduled clinics had to be cancelled. Some staff did not book any appointments in advance, instead deciding which patients to prioritise depending on the capacity they had that day.
- Staff spent a lot of time rescheduling clinics, contacting patients, and rebooking appointments. However, they did not always record the cancelled clinics and appointments on the electronic system, which meant it was difficult to obtain accurate data on the extent of the problems faced by the service.
- A dedicated reception nurse assessed new arrivals and co-ordinated reviews of patients prior to court appearances, hospital appointments, prison transfers and releases. The substance misuse service offered patients Naloxone on discharge. Naloxone is a medication used to reverse or reduce the effects of overdose by opioid drugs.
- The service had developed an effective social care pathway with Lancashire County Council. This included clear referral, assessment and care planning processes, which worked well. Administrative staff managed a social care tracker, which was well organised, easy to understand and up to date.

Facilities that promote comfort, dignity and privacy

- Most healthcare services were provided from a designated healthcare unit with some activities provided on wings. However, at the time of our inspection, wing-based care had ceased temporarily due to a heightened level of security in the prison.
- The healthcare unit had limited clinical space with only 6 rooms available to deliver all primary care services including GP sessions, physiotherapy, podiatry and nurse-led clinics. This meant planning of clinics needed to be completed well in advance.
- The healthcare unit had a small waiting room but patients had no access to bathroom facilities while they were waiting. This mostly affected patients from E, F and G wings who were escorted to the waiting room in groups and had to wait for all their appointments to be completed before they could return to their wings. The recent health needs analysis published in May 2023 reported patients, "often opt not to come to healthcare due to the waiting room set up." The provider told us that the prison had plans to develop a clinic room on E and F wing but progress was slow.

Meeting the needs of all people who use the service

- The provider offered a wide range of health and social care services that included primary care, mental health, substance misuse services and social care. The provider worked closely with other services provided at the prison such as dentistry, optometry, physiotherapy, podiatry and trauma therapy. Community healthcare services visited the prison to offer x-ray and ultrasound services on site.
- The primary care team offered a range of clinics led by GPs, nurses or healthcare support workers that included long-term conditions, weight management, and health checks.

Inspected but not rated

Are services responsive to people's needs?

- The mental health team offered a range of clinical and psychological services. Nurses ran a weekly clinic for patients in receipt of treatment by depot injection. However, due to a vacancy for a healthcare assistant, the service was not up-to-date with health checks for eligible patients. Psychology staff offered a range of 1-1 interventions but had not been able to offer groups due to a lack of suitable rooms. This had been rectified and planning was underway for some groups to start in the near future.
- The dedicated learning disability and neurodiversity nurse worked alongside the prison's neurodiversity lead to identify prisoners with learning disabilities, attention deficit hyperactivity disorder and autism. The nurse offered specialist assessments that helped identify people's communication needs and any reasonable adjustments they required such as the provision of ear defenders or stereo, or a move to a quieter cell.
- The clinical substance misuse team worked closely with DARS to offer a range of clinical and psychosocial interventions. Clinical staff attended reception to see any new prisoners who had substance misuse problems. DARS supported the prison's drug recovery unit as prisoners had to agree to engage in groups to reside on this unit.
- Staff made referrals for social care assessments for people who needed aids and adaptations. People received the equipment they needed to help them stay safe and maintain their independence. At the time of our inspection, there were no prisoners in receipt of social care packages. However, some prisoners were eligible for low level peer support with non-intimate care. A formal buddy support programme provided by RECOOP was being implemented jointly between the provider, prison, and local authority. In the meantime, people had access to prison wing buddies.
- Staff made referrals to secondary care when needed. The service used a spreadsheet to track referrals, appointments, and cancellations. However, this did not show a full picture of the patient's care journey, for example, whether they had attended. We looked at 4 patients with cancelled appointments and could not find an up-to-date status for 3 of them.

Listening to and learning from concerns and complaints

- Patients had access to a dedicated healthcare complaints system, however, the service did not always investigate and respond to complaints in line with the provider's policy, and the quality of responses varied.
- We reviewed a random sample of 6 complaints and the responses sent to patients. These were not dealt with in a timely manner, the service did not always offer an apology, and responses lacked information on how a patient could escalate their concern within the trust or to the health ombudsman.
- Staff did not regularly collect completed complaints forms from the wings. For example, we found 9 complaints forms dated between 7 August and 23 August 2023 that the service received on 7 September 2023.
- There was minimal quality assurance of the complaints process and staff responding to complaints had not received the relevant training.
- The provider conducted regular audits of complaints but we found little evidence of progress made with consistent themes of concern related to general healthcare and medicines.

Inspected but not rated

Are services well-led?

Leadership

- The healthcare service was led by an experienced and skilled head of healthcare supported by a local team of suitably qualified managers and staff.
- The head of healthcare regularly shared her concerns about the prison regime and culture to the prison governors and to the trust. At the time of our inspection, the trust had submitted a report to the prison governor to escalate their concerns about the increase in volatility and risk at the prison and the impact of this on the delivery of healthcare.
- The staff we spoke with described their local managers as visible and approachable.

Vision and strategy

- The provider had an integrated service model across healthcare. Aside from the shared responsibilities for medicines administration, staff found the model confusing and ineffective. In particular, specialist staff in the substance misuse and mental health team expressed concern about being deskilled in their specialism and not being sufficiently skilled in other areas. The provider had started to explore the option of separating these services to improve the specialisms.

Culture

- Most of the staff we spoke with said they felt supported and valued. They could raise concerns, discuss issues and share ideas. They showed a strong commitment to their colleagues and patients and worked diligently and flexibly to provide a full service in challenging circumstances.
- Staff morale varied. Most staff we spoke with told us they "love it here", and "we have the opportunity to do meaningful work." However, they also expressed frustration about the time spent on medicines administration due to staffing shortfalls and poor operational support from the prison, and the impact of this on their other duties.

Governance

- The trust had clear governance structures that supported the healthcare service at the prison. These included an organisational structure and a range of local and provider level meetings, for example, monthly clinical governance meetings, monthly local delivery board, quarterly contract meetings with NHS England, a quarterly northwest prisons health and social care partnership board and regular drug strategy meetings.
- The trust had policies and procedures to cover the full range of functions. In addition, the healthcare service at the prison had local operating protocols where needed. However, some GMMH policies were overdue for review and/or out of date.
- Staff completed a range of relevant audits that included checks on NEWS2, infection control, controlled drugs, 'in possession' risk assessment reviews when ACCTS were opened, hand hygiene, and record keeping. Some audits resulted in improvements, for example, a recent audit of emergency calls data had resulted in additional triage training for staff. However, some audits did not always lead to improvements. For example, audits did not identify gaps in medicines administration records; actions following audits did not address the issues found with reception processes and themes emerging in complaints.

Management of risk, issues and performance

- In primary healthcare, the number of clinics cancelled were not accurately reflected on SystmOne, which made it difficult to assess the extent of the problem.

Inspected but not rated

Are services well-led?

- It was not possible to establish the frequency and severity of staffing shortages as daily deficits in staffing were not recorded on the rota. Safer staffing levels within primary care had yet to be agreed by the trust. In cases where managers and leads covered staffing shortfalls, these were not reported as incidents.
- The spreadsheet for managing external appointments was not up-to-date and did not provide a complete picture of the patient's attendance or completed care journey.
- Medicines records were not completed accurately, and audits did not reflect the number of doses of medicines that had not been administered or had not been recorded as administered.
- There were delays in collecting and responding to complaints, the quality of responses was varied, and there were no quality checks in place. Staff had not received training in handling complaints.
- The service collated a wide range of data required to assess and monitor service delivery, identify issues and risks, and plan improvements, for example, clinic non-attendance rates, cancelled external appointments, waiting lists, caseloads, complaints and incidents.
- The service maintained a risk register, which included the main risks the service faced. Recruitment and retention of staff presented the biggest challenge but the provider was committed to improving this with a renewed focus and ideas, for example, offering student placements, and 'growing their own' via training and development opportunities.

Engagement

- The provider worked with a range of subcontracted and other providers to deliver a comprehensive health and social care service.
- There was a joint memorandum of understanding (MOU) between the prison, the provider and the local authority that covered the arrangements for social care. At the time of our inspection, the local authority was in the process of finalising an updated version, and it was not yet available for distribution.

Learning, continuous improvement and innovation

- The service had made improvements to medicines management in response to the regulatory breach.
- The service had action plans in place to address issues identified in audits, for example, NEWS2, controlled drugs, and infection control.
- The provider had started discussions with commissioners about implementing the recommendations of the updated health and social care needs analysis issued in May 2023.
- The provider had made links with community services to implement pathways for anti-coagulation and memory assessment services.

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 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • There were delays in collecting and responding to complaints, the quality of responses was varied, and there were no quality checks in place. Staff had not received training in handling complaints. • The spreadsheet for managing external appointments was not up-to-date and did not provide a complete picture of the patient's attendance or completed care journey. • It was not possible to establish the frequency and severity of staffing shortages as daily deficits in staffing were not recorded on the rota. Safer staffing levels within primary care had yet to be agreed by the trust. In cases where managers and leads covered staffing shortfalls, these were not reported as incidents. • In primary healthcare, it was difficult to assess the extent of the problems faced by the service as the number of clinics cancelled were not accurately reflected on SystmOne. • Some audits were not effective. For example, the actions taken did not address the issues found with reception processes and themes in complaints; audits did not identify gaps in medicines administration records.

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Medicines records were not always completed accurately. We found administration records that were left blank or had limited details recorded so it was unclear if and why prisoners had missed their medicines.

This section is primarily information for the provider

Requirement notices

- Pharmacy staffing shortages meant that staff could not always complete their required tasks in a timely way, for example, medicines reconciliation.
- Not everyone had current compact agreements (for HMP Garth).