HMP Manchester

Inspection report

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Date of inspection visit: 10 August 2022 - 11 August 2022
Date of publication: 15/09/2022

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 well-led?	**Inspected but not rated**

Overall summary

We carried out an announced focused inspection of healthcare services provided by Greater Manchester Mental Health NHS Foundation Trust (GMMH) at HMP Manchester to follow up on the requirement notices issued after our last inspection in September 2021. At the last inspection, we found the quality of healthcare provided by GMMH at this location required improvement. We issued requirement notices in relation to Regulation 17, Good governance and Regulation 18, Staffing.

The purpose of this focused inspection was to determine if the healthcare services provided by GMMH were meeting the legal requirements of the requirement notices; determine if the provider was 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.

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:

- New systems and processes had been implemented to strengthen governance of the service and these operated effectively to ensure performance and risk were managed.
- Staff received basic training to keep people safe from avoidable harm.

Our inspection team

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

How we carried out this inspection

Before this inspection we reviewed some information that we held about the service including notifications and action plan updates.

During the inspection visit, the inspection team spoke with:

- Head of healthcare and primary care team manager
- Six other staff members; including nurses, pharmacy staff and administrators
- Observed the daily clinical handover meeting.

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

- Primary care clinical review meeting minutes
- Healthcare staff meeting minutes
- Local clinical governance meeting minutes
- Monthly incident bulletins
- Continuous Professional Development sessions
- Patient safety meeting minutes
- Standard operating procedures
- Training needs analysis

Background to HMP Manchester

- HMP Manchester is a local category B training prison, retaining a small category A function and separate close supervision centre. The prison is located on the outskirts of Manchester city centre and accommodates approximately 740 prisoners. The prison is operated by Her Majesty's Prison and Probation Service.
- Health services at HMP Manchester are commissioned by NHS England & Improvement. The contract for the provision of healthcare services is held by Greater Manchester Mental Health NHS Foundation Trust (GMMH). GMMH is registered with CQC to provide the regulated activities of diagnostic and screening procedures, assessment or medical treatment for persons detained under the Mental Health Act (MHA) 1983 and treatment of disease, disorder or injury.
- Our previous comprehensive inspection was conducted jointly with Her Majesty's Inspectorate of Prisons (HMIP) in September 2021 and published on the HMIP website on 21 December 2021. We found breaches of Regulation 17, Good governance and Regulation 18, staffing.

Report on an unannounced inspection of HMP Manchester by HM Chief Inspector of Prisons 6-7 and 13-17 September 2021 (justiceinspectorates.gov.uk)

Inspected but not rated

Are services safe?

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it, this means staff are competent to do their roles.

At our last inspection we found that not enough staff had completed required mandatory and essential training. This included moving and handling in-patients, basic life support, safeguarding adults and children, Mental Capacity Act, MHA Code of Practice and training in vulnerable adults and people with a learning disability.

At this inspection, we found that staff had completed and kept up to date with their mandatory and essential training, overall compliance at 10 August 2022 was 89%. At our last inspection 83% of staff had completed immediate life support training, at this inspection this had reduced to 80%. However, staff with outstanding training were booked onto courses to be completed by the end of August 2022.

All staff who work on the in-patient unit had completed training in moving and handling patients.

Staff now received protected time to complete their training and since our last inspection, GMMH provided a dedicated IT space for staff to complete training. Managers monitor mandatory training and alert staff when they need to update their training.

GMMH completed a training needs analysis in January 2022 to support the development of staff and the service. Staff recently completed additional professional training in catheterisation and suturing.

Inspected but not rated

Are services well-led?

Good Governance

Governance processes operated effectively at team level and performance and risk were managed well. This improved patient safety and service delivery.

At our last inspection we found systems or processes in place were not effective in assessing, monitoring and improving the quality and safety of the services being provided. In particular, the primary care team did not meet regularly and there were no meetings which included staff from primary care, mental health, in-patients and social care.

At this inspection, we found that systems, processes and procedures had improved to help managers accurately assess, monitor and improve the safety and quality of the service. For example, the primary care team met regularly to discuss relevant team issues and team managers from the primary care team, in-patient unit, mental health team, pharmacy and substance misuse service met monthly.

Standardised agendas and minutes from both meetings demonstrate a range of topic discussions, such as service updates, incidents, mandatory training compliance, supervision, complaints, safeguarding, workforce recruitment and performance. Meeting minutes evidence there is a flow of information from managers to staff; discussions and information from the managers meeting is shared with staff in team meetings and clinical handovers. This meant staff regularly shared information between the different healthcare teams to monitor and effectively manage patient safety and improve patient outcomes.

At our last inspection we found information relating to learning from incidents was minimal and structured feedback, including themes and trends was not provided to staff.

At this inspection, we found managers took a consistent approach to learning from incidents and sharing information with staff. Staff told us managers produce a monthly incident bulletin; this is specific to HMP Manchester and highlights good practice, areas for improvement, recommendations and lessons learned. Staff receive the bulletin via email and discuss incidents in staff team meetings. Information relating to reported incidents is on display in the staff room. This helped reduce repeated incidents and future risks.

Managers also use examples of learning from incidents from across health and justice locations to inform monthly continuous professional development sessions. A recent example includes the use and availability of critical medicines.

At our last inspection we found a range of equipment was out of date; including dressings, syringes, bio-hazard cleaning kits and defibrillator pads. Also, we found that paperwork within one emergency bag was blood stained.

At this inspection we found staff had introduced some new procedures in relation to stock control and checking equipment, these procedures were effective in monitoring the quality and safety of the service. Staff regularly checked emergency equipment and stock control on the wings had improved and this was managed well. This meant that staff were well equipped to attend medical emergencies and meet the needs of patients.

At the last inspection we found systems or processes in place were ineffective in assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users.

Staff did not always follow up on the outcome of medical testing. Test results from a procedure completed in August 2020 remained outstanding at the time of the inspection in September 2021.

Inspected but not rated

Are services well-led?

During this inspection we reviewed a new procedure that had been implemented to support the follow up of medical test results and discharge information following hospital appointments. We examined two care records and each record demonstrated how the process had been embedded into practice. Administration staff manage the process and oversight is maintained by the head of healthcare. This process has reduced risk and improved practice and outcomes for patients.

At the last inspection we found that staff did not record when an insulin pen had been opened and an out of date vaccination was stored in a clinical fridge.

During this inspection we found staff had introduced a new procedure for the management of treatment rooms. This included the removal of all vaccines from wing-based treatment rooms and the appropriate labelling of insulin pens. We observed that staff completed the required checks of all treatment room fridges and staff did not store vaccines on the wings. This meant medicines management was safe and the risk to patients had reduced.

At the last inspection we found that medicines were not delivered directly to the pharmacy, which meant they were unsupervised, potentially rendering the supply chain insecure. At this inspection GMMH told us the process had been assessed by the Home Office and the safety of the process deemed appropriate. The CQC medicines team confirmed this is adequate and no further information has been requested.