HMP Liverpool

Quality Report

68 Hornby Road
Liverpool
Merseyside
L9 3DF
Tel: 0151 530 4000
Website:

Date of inspection visit: 11 - 14 September 2017
Date of publication: 15/12/2017

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.

Contents

Overall summary

Summary Letter

We carried out an announced focused inspection of HMP Liverpool between 11 and 14 September 2017, alongside a comprehensive joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) under our memorandum of understanding. The focused inspection was in response to previous breaches of our regulations, and to concerns raised by whistle blowers about patients' experience at HMP Liverpool. Some of these related to prison issues outside the remit and control of Lancashire Care NHS Foundation Trust (LCFT). HMIP will publish the joint report separately at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections

Summary of findings

CQC do not currently rate services provided in prisons.

The background to inspection activity for HMP Liverpool is:

- In May 2015 we carried out a joint comprehensive HMIP and CQC inspection. Breaches of regulations led to CQC issuing four Requirement Notices to improve care against: Regulation 9, - Person centred care; Regulation 10 - Dignity and respect; Regulation 12 - Safe care and treatment, and Regulation 16 - Receiving and acting on complaints.
- In July 2016 we undertook a CQC-led focused inspection. We found the trust had made some improvements. However, further breaches in some areas led to CQC issuing two further Requirement Notices against Regulation 9, - Person centred care and Regulation 12, - Safe care and treatment.
- CQC decided to follow up these breaches by carrying out a focused follow up inspection alongside the planned joint comprehensive inspection with HMIP in September 2017.

During this inspection, we found that issues identified in the inspection in 2016 had mostly been addressed, and there were improvements in some aspects of care. However, we also found a number of other areas where Lancashire Care NHS Foundation Trust must make improvements.

Importantly, the trust must ensure that:

- Complaints are investigated effectively and in a timely way with appropriate action to address patients' concerns.
- Complainants are kept informed of the status of their complaint and its investigation.
- Complaint monitoring actively informs service improvement and learning is shared with staff to improve patient care.
- Appropriate monitoring and recording of prescribing errors is embedded to improve prescribing safety and patient care.
- Patient engagement informs the delivery of services and service improvement.
- Governance arrangements for the dental service are robust; including monitoring the quality of x-rays and sharing learning from audits to improve patient care.
- Clear and accurate records are kept in relation to staffing rotas that support effective monitoring.
- Clinical staff receive appropriate managerial and clinical supervision in line with trust policy.
- Clear and accurate up to date records are kept in relation to staff supervision.
- Staff receive regular appraisal of their performance.
- Staff conducting detoxification reviews are appropriately supported by clinicians.

Additionally the trust should:

- Ensure systems to monitor the safe storage of medicines are effective.
- Routinely update emergency medicine expiry dates where they are stored out of refrigerators, in line with guidance.
- Implement comprehensive reporting and escalation systems in relation to regime activity on the inpatient unit.
- Ensure that patients on detoxification regimes are monitored appropriately in line with guidance.
- Implement an action plan to build on the cultural values assessment carried out in August 2017 to support staff and patient care.
- Ensure there is sufficient management oversight and staffing during the remainder of the service contract.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that while Lancashire Care NHS Foundation Trust was providing reasonably safe care in accordance with the relevant regulations, there remained a range of concerns about the environment, governance, and staffing levels which posed a risk to patients.

- Most incidents were being reported by staff and investigated by managers.
- Governance arrangements were not sufficiently robust around recording prescribing errors, refrigerator temperature monitoring and accuracy of emergency medicine expiry dates.

Healthcare staff were unable to monitor patients on detoxification regimes overnight and there was no clinical involvement in the five-day reviews in line with guidance.

Are services effective?

We found that although the trust had made a number of improvements since our previous inspection, LCFT was not providing effective care in accordance with the relevant regulations.

- Improvements made since our previous inspection included community equivalent NHS screening and long-term condition management.
- The trust had taken appropriate and sustained action to recruit to fill staffing vacancies, and recruitment issues were routinely discussed with NHS England at partnership meetings, however, vacancies continued to impact on the team's ability to deliver effective care; in particular the monitoring of patients who were experiencing mental health problems.
- Whilst the trust carried out a range of audits and complaints monitoring, these were not embedded within the prison healthcare team to improve patient care.
- Many staff did not receive regular supervision or timely performance reviews.
- The psychiatrist provision did not meet the needs of patients.
- The Talking Therapies team delivered a range of interventions to support prisoners with low-level mental health conditions.
- Whilst patients did not have access to discuss their medicines with a pharmacist, GPs and pharmacy technicians did support patients with their medicines.

Summary of findings

Are services caring?

We found that LCFT was providing caring services in accordance with the relevant regulations.

- We observed a range of caring interactions between patients and staff.
- Staff delivered personalised care despite the complex working environment.
- Care planning had been effectively introduced for patients with long-term conditions.

Are services responsive to people's needs?

We found that LCFT was not always providing responsive care:

- Patients experienced waits for up to four months for written responses to complaints.
- There was a regular forum for up to 26 patients residing in the inpatient unit, but no engagement with the remainder of the 1,155 patients through survey or forum groups.
- Prisoner perceptions were poor, especially around referrals to secondary care and escorts to external hospital appointments.
- Some improvements had been introduced by the trust in order to meet the needs of the patient population, for example reintroducing community and screening pathways, appointing a permanent long-term condition nurse and integrating the mental health and substance misuse services.
- Most routine GP appointments took place within two weeks.
- Urgent GP appointments were available daily, along with nurse led triage and long-term condition management.

Are services well-led?

We found LCFT was not providing well-led care.

- There was evidence of continual improvement and improvements to patient care.
- The trust had ensured recruitment remained an ongoing priority and this was discussed with commissioners and prison management regularly.
- Wider trust governance systems were not all effectively embedded into HMP Liverpool.
- Staff told us they felt supported by local management but not by the wider trust.
- Patient engagement was good for inpatients but did not take place for prisoners living on the main residential units.

Summary of findings

- The trust had carried out a staff cultural values assessment (CVA) as part of engagement and team building in August 2017, however, no action plan to take this forward was in place at the time of the inspection.
- The trust's decision to give notice to withdraw from the contract to provide services at HMP Liverpool coincided with the CVA report publication and contributed to staff feeling devalued by the trust.
- There remained a number of areas where healthcare treatment was not sufficiently prioritised by partnership working with prison staff and managers. Whilst healthcare staff reported some incidents through the trust reporting system, they did not always escalate to prison management when it would be appropriate to do so, and monitoring arrangements were insufficient to evidence escalation and reporting.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Importantly, the trust must ensure that:

- Complaints are investigated effectively and in a timely way with appropriate action to address patients' concerns.
- Complainants are kept informed of the status of their complaint and its investigation.
- Complaint monitoring actively informs service improvement and learning is shared with staff to improve patient care.
- Appropriate monitoring and recording of prescribing errors is embedded to improve prescribing safety and patient care.
- Patient engagement informs the delivery of services and service improvement.
- Governance arrangements for the dental service are robust; including monitoring the quality of x-rays and sharing learning from audits to improve patient care.
- Clear and accurate records are kept in relation to staffing rotas that support effective monitoring.
- Clinical staff receive appropriate managerial and clinical supervision in line with trust policy.
- Clear and accurate up to date records are kept in relation to staff supervision.
- Staff receive regular appraisal of their performance.
- Staff conducting detoxification reviews are appropriately supported by clinicians.

Action the service SHOULD take to improve

Additionally the trust should:

- Ensure systems to monitor the safe storage of medicines are effective.
- Routinely update emergency medicine expiry dates where they are stored out of refrigerators, in line with guidance.
- Implement comprehensive reporting and escalation systems in relation to regime activity on the inpatient unit.
- Ensure that patients on detoxification regimes are monitored appropriately in line with guidance.
- Implement an action plan to build on the cultural values assessment carried out in August 2017 to support staff and patient care.
- Ensure there is sufficient management oversight and staffing during the remainder of the service contract.

HMP Liverpool

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Health and Justice inspector. The CQC focused inspection was conducted by two CQC Health and Justice inspectors; and one CQC specialist professional dental advisor also attended for one day. The wider joint team included a range of core inspectors and two Her Majesty's Inspectorate of Prisons (HMIP) health inspectors, along with one inspector from the General Pharmaceutical Council who attended for one day. These specialists also provided expertise for this CQC focused inspection.

Background to HMP Liverpool

HMP Liverpool is a local prison for remand and sentenced adult males in the Merseyside area. At the time of the inspection, there were 1,155 prisoners in custody. Lancashire Care NHS Foundation Trust (LCFT) provides primary physical and mental healthcare, secondary mental healthcare, dentistry, substance misuse and social care services to men detained at the prison. The location, HMP Liverpool is registered to provide the regulated activities, diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury. The provider, LCFT informed NHS England in August 2017 that they intend to withdraw from the contract from 1 April 2018. NHS England is currently undertaking a procurement exercise for the provision of healthcare services at HMP Liverpool.

Why we carried out this inspection

CQC inspect under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

CQC inspected healthcare services at the prison in partnership with HMIP in May 2015 and found the trust was in breach of four regulations. The report and information on the joint methodology can be found by accessing the following website:

http://www.cqc.org.uk/content/health-and-care-criminal-justice-system.

In this joint report we told the trust they must make improvements against four regulations:

- Regulation 9 - Person centred care;
- Regulation 10 - Dignity and respect;
- Regulation 12 - Safe care and treatment;
- Regulation 16 - Receiving on and acting on complaints.

CQC followed up these regulatory breaches during a focused inspection in July 2016. We published a focused follow up report on 26 September 2016, issuing two Requirement Notices to the trust, against Regulation 9 - Person centred care and Regulation 12, - Safe care and treatment. This report can be found on the CQC website: http://www.cqc.org.uk/location/RW5FY

The trust submitted an action plan to CQC to say how they would address the breaches identified.

Since the 2016 inspection report was published, CQC have received a number of whistle blowing concerns which we followed up during this focused inspection. Details of our findings in relation to these have been included in this report.

Detailed findings

At the same time as this focused inspection, HMIP and CQC carried out a comprehensive joint inspection of HMP Liverpool between 11 and 14 September 2017. The findings and joint inspection report will be published separately on HMIP website at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections

We found evidence that the trust had addressed many of the concerns that we identified during our inspection in July 2016 and made the improvements that were required. The local management team was committed to delivering quality patient care.

However, managerial and governance support was insufficient. The location was not compliant with a range of wider trust policies and procedures and there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Some areas of concern raised by the whistle blowers related to areas outside LCFT's control and remit and will be further reported within the joint HMIP/CQC inspection report.

There were areas of poor practice where the trust needs to make improvements.

How we carried out this inspection

Before the inspection we reviewed a range of information about the health and social care services at HMP Liverpool, provided by the trust. During and after the inspection visit we requested additional information which we reviewed.

We informed the NHS England area commissioning team that we were inspecting the prison, as well as a Member of Parliament (MP) who had escalated the whistle blowers' concerns with CQC. We received information about the quality and performance of the service from NHS England and further information from the MP.

Additionally, we reviewed our previous inspection reports; Prison and Probation Ombudsman reports of deaths at the prison since the last inspection; the Independent Monitoring Board reports for 2015 and 2016 as well as media reports relating to the location.

To get to the heart of patients' experiences of care and treatment, CQC always ask the following five questions:

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

Are services safe?

Our findings

We did not inspect the safe key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued following the inspection in July 2016 and concerns raised to CQC by whistle blowers.

At our inspection in July 2016 we found a range of concerns in relation to medication storage and monitoring including:

- Medicines were being stored outside the recommended temperature range to ensure their suitability for use.
- Inconsistences in the auditing of controlled drugs.
- Prescription tracking systems were being developed, but had not been implemented.

Concerns raised by the whistle blowers included an allegation that incidents were not being acted upon by management; a range of concerns around medication management, poor practices in substance misuse treatment, and observations of patients at risk not always taking place.

Safe track record and learning

During this inspection we found that most incidents were being reported appropriately. However, where prescribers made prescribing errors, the pharmacist addressed these errors promptly but did not record them or raise them with the prescriber. This meant that lessons were not being learned and shared with prescribers to help avoid future errors. A CQC inspector had raised this with trust staff during the 2016 inspection, but action had not been taken to address the situation.

In the six months prior to the inspection 541 incidents had been reported by healthcare staff, 65 of which were still being reviewed by management. Appropriate actions were taken in response to incidents, and learning identified, but arrangements to ensure that learning from incidents was systematically shared and reviewed with staff were insufficient.

Medicines management

The trust had improved arrangements for maintaining the integrity of medicines since our previous inspections. When we reviewed recent records we found that recorded medicine refrigerator temperatures and room temperatures were appropriate. However, during this inspection we found one emergency medicine, glucagon (used for treating hypoglycaemia. This has a shortened expiry date when removed from the refrigerator), which was stored at room temperature with no indication of its revised expiry date. The evidence did not clearly show how staff monitored and adjusted the expiry dates in line with guidance.

Although the trust had introduced systems to improve medicines safety, including auditing medicines storage procedures, the systems were not always operating effectively. In August 2017, following a safe storage of medication audit which identified previous occasions when temperatures were not being checked daily, staff had not checked one fridge on four consecutive days. Managers we spoke with were not aware of the omission and could not confirm who was responsible. We did not see evidence that storage temperatures affected the safety of the medication, but could not be assured that associated risks were adequately managed.

Electronic prescribing had been introduced which meant that prescriptions were now appropriately tracked. This system was also used to provide range of monitoring around safe prescribing. This included highlighting drug interactions, and pharmacist reviews of prescriptions for newly received patients.

Medication administration remained an issue, due to insufficient prison staff supervision, and the potential for diversion of tradeable and potentially addictive medicines.

Monitoring risks to patients

We found a range of examples of safe care and good risk management by staff including occasions when they had intervened jointly with prison staff over patient safety.

For patients with substance misuse and detoxification needs, an assessment took place on arrival at HMP Liverpool, which included drug and alcohol use screening. A GP reviewed all new arrivals and was responsible for initial detoxification prescribing, a substance misuse doctor undertook all prescribing for opiate stabilisation and alcohol detoxification prescribing.

There was no dedicated detoxification/ stabilisation unit at HMP Liverpool. Men were monitored in the first night wing or on other residential units; however, overnight observation of these men was not taking place as staff could not see into or access cells. Ongoing reviews took

Are services safe?

place for all men who were treated for substance misuse; these were carried out by a health care assistant without appropriate prescriber input. Health staff had been trained to look for signs of over-sedation, signs of withdrawal, infection, sepsis and general indicators of possible illness as part of the review but they did not always have sufficient skill and experience around more complex clinical information and potential risk factors.

We saw regular health staff contribution to the monitoring of men supported under the Assessment, Care in Custody, Teamwork (ACCT) procedures, which are used by prison staff to support prisoners who might be at risk of suicide or self-harm. CQC only consider healthcare staff's contribution to ACCT. Procedures were fully reviewed during the joint inspection with HMIP and will be included in the comprehensive joint report.

Are services effective?

(for example, treatment is effective)

Our findings

We did not inspect the effective key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued following the inspection in July 2016 and concerns raised to CQC by whistle blowers.

During our inspection in July 2016, we found a range of concerns around care planning and the management of risks for patients including:

- The trust did not have systems in place to monitor and support patients with long-term conditions.
- Many men with long-term conditions did not have care plans in place.
- Staffing shortages within the primary care team meant that nurse led clinics did not happen regularly.
- Patients with mental health conditions who were in crisis and those with complex needs were seen promptly, but patients with mild to moderate depressive/anxiety type illness waited longer to receive a service.
- Medication reviews were not routinely happening, although some prisoners had the opportunity to discuss and review their medicines during routine GP appointments.

The whistleblowing concerns shared with CQC included allegations that there was insufficient:

- Psychiatrist support to patients with severe mental health conditions.
- Health care staff to adequately care for patients.

Effective needs assessment

The trust had introduced a nurse-led long-term condition clinic. We saw clear prioritisation of patients who required support for their health care conditions and care plans were in place for over 150 patients at the time of the inspection. The waiting list had been reduced to 78 patients. The nurse had a clear plan to develop long-term condition management for this population group over the coming months.

Management, monitoring and improving outcomes for people

The healthcare team had made significant improvements to the reception health screening arrangements for the vast numbers of men arriving from courts weekly. These meant that risks were effectively identified on arrival. However, the secondary screening process did not always take place and we had concerns potentially vulnerable men were not being prioritised for secondary screening.

The integrated mental health team were unable to fully meet the needs of patients. We saw examples of men on individual clinicians' caseloads who were listed to see the duty mental health worker because caseworkers had insufficient capacity to meet the needs and monitor patients effectively. This impacted on relationship building and consistency of care.

The trust had increased the provision to support patients with mild to moderate anxiety and depression through development of the Talking Therapies team, which now provided excellent support to over 130 patients. Patients could access a range of cognitive behavioural therapy based interventions and person centred counselling.

At the time of this inspection, there was still no access for patients to speak with the pharmacist about their medication as they could in the wider community. However, we saw clear evidence in patient clinical records where GPs had discussed medication with patients, and we observed pharmacy technicians giving appropriate advice during medicines administration times. Pharmacy technicians, and GPs were able to escalate individual cases to a pharmacist where required. This assured us that patients received appropriate advice about their medication.

LCFT had carried out a number of audits but the evidence we saw suggested that learning from audits was not embedded into the prison healthcare service to improve patient care. For example, the trust had carried out an audit on the safe and secure storage of medicines in June 2017. This audit noted some gaps in the recording of refrigerator temperatures, yet we found a further example from August 2017, where staff did not record one refrigerator temperature for four days.

Likewise, during the inspection, we spoke with dental staff who were unaware of a clinical records audit which had been carried out in November 2016. A range of actions and learning stemming from this audit had not been implemented at the time of this inspection. During the

Are services effective?

(for example, treatment is effective)

inspection, no radiograph quality checks or audits had been carried out, although the trust provided evidence that a radiograph quality audit was carried out during October 2017 subsequent to the inspection.

Effective staffing

The trust had made sustained efforts to improve staffing through ongoing recruitment, attending job fairs and by introducing new staffing structures. This included forming an integrated substance misuse and mental health team to improve the support offered to men with substance misuse and mental health needs.

The trust used agency staff where possible to fill staffing vacancies, although this did not cover all shortfalls, particularly gaps in mental health and primary care owing to sickness and vacancies. A number of posts had been recruited to with some candidates awaiting security clearance at the time of the inspection, although this did not cover all the vacancies. There was also a number of management posts either vacant or where post holders had been absent for some months. No arrangements were in place to cover these posts at the time of the inspection. The trust routinely discussed staffing with NHS England commissioners at partnership meetings as well as with prison management.

Nurse led clinics were now happening routinely, and the trust had amended the staffing structure to improve patient care by replacing six primary care nurse vacancies with pharmacy technician posts to assist with medication administration. The pharmacy technicians were trained to carry out basic clinical observations and were able to discuss medicines queries with patients during medication administration times, which improved patient care.

Staffing shortages impacted on patient access to mental health services. There were over 100 patients on waiting lists to see mental health nurses at the time of our inspection. Some patients with complex mental health care needs had waited between three and five months to be seen.

Performance development, clinical and managerial supervision had not been implemented within the prison healthcare team in line with the trust's policy. Most primary and mental health care nurses had no supervision recorded, and one staff member told us they had received supervision once in 14 years. The senior clinical management team had embedded team supervision into management meetings and the Talking Therapies team all received regular supervision. Supervision and performance review records did not include the names of some current staff.

There were two consultant psychiatrists allocated to help care for men with complex mental health conditions, who were scheduled to attend the prison for eight sessions per week. During June, July and August, only 21, 14 and 15 sessions (respectively) were delivered. There was no cover for psychiatrists' planned or unplanned absence, which was included on the risk register for the prison location. This impacted upon waiting times and continuity of care for patients with complex mental health conditions. For example, one patient waited 10 weeks to see a psychiatrist, others were informed they would be seen within specified timescales but waited several weeks longer for these appointments.

Are services caring?

Our findings

We did not inspect the caring key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued as a result of the inspection in July 2016.

The issues identified as requiring improvement in 2016 included care planning and support for vulnerable patients.

We observed a range of caring interactions between patients and staff in all health and social care services. There were appropriate care plans in clinical records for most patients who had complex mental and physical health conditions.

During the inspection, we saw evidence of personalised care being delivered despite the pressures on staff and the complex working environment. This included:

- Care plans were in place for patients with physical and mental health conditions which demonstrated effective identification of concerns and patient involvement in their care plans.
- Staff interacting in a caring manner with patients through cell doors.
- Nurses going to find vulnerable men who had not attended to collect medication and intervening with prison staff where additional monitoring was required.
- Staff contributing to the prison assessment, care in custody and teamwork (ACCT) procedures to support patients identified as at risk of self-harm or suicide.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect the responsive key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued following the inspection in July 2016.

During our inspection in 2016, we found that access to a GP for routine appointments was not equivalent to community access and patients living in the inpatient unit had to request complaint forms.

Access to the service

Patients we spoke with had poor perceptions about access to healthcare, and several told us of their frustrations in delays and cancellations of external hospital appointments. For prisoners living in main residential accommodation, we found the prison regime routinely affected patients' ability to attend their internal and external healthcare appointments particularly when prison officers were unavailable to unlock them or escort them to healthcare.

The number of appointments where the patient did not attend (DNA) remained high; the most recent DNA performance indicators showed that between October 2016 and March 2017 45% of patients did not attend their booked appointments. Healthcare staff now maintained robust audit trails and records in relation to and records of appointment slips being handed to identified prison staff and requested reasons as to why patients did not attend.

During the inspection, prisoners we spoke with told us that they were able to get appointments if they needed to be seen urgently, however, they told us it was difficult to get a routine appointment. This was evidenced in the prisoner survey carried out by HMIP prior to the joint inspection where only 16% of the 190 men who submitted surveys said it was easy to see a GP.

Records showed that 10 to 15% of planned escorts to external hospital appointments each month were cancelled or delayed owing to a lack of prison staff. However, in August 2017, prison staff facilitated only 76% of requested external hospital appointments. Lancashire Care Foundation Trust had implemented monitoring and processes to ensure that patients with high clinical need were prioritised for external escorts.

During this inspection, we again noted that the clinical staff lacked control of patient admissions to the inpatient unit, as admissions continued to be managed by the prison. This had been previously raised as a concern by HMIP and the prison's Independent Monitoring Board. The outcome of this was that admissions were often not based on clinical need, with some unwell patients remaining in main prison accommodation because men without clinical need occupied inpatient beds. We saw one patient whose mental health deteriorated significantly whilst waiting for admission to the inpatient unit during this inspection.

Listening and learning from concerns and complaints

During this inspection, we found a well-established patient forum for inpatients was in place, allowing those patients in the inpatient unit (up to 26 out of a prison population of approximately 1,155 during the inspection) to raise concerns and engage with what the prison and healthcare could provide. An independent Healthwatch advocate now chaired this meeting, which was an excellent initiative. We saw evidence that many concerns were addressed during this forum, though the lack of sufficient prison staff to facilitate basic prison regime activities remained unaddressed, resulting in patients having insufficient access to fresh air and showers. This was outside the trust's direct control.

Despite the well managed inpatient forum, there was no evidence of the trust's engagement with the wider prisoner population or surveys carried out to contribute to service improvement.

The complaints process was well embedded, monitored by the Hearing Feedback team at LCFT. In January 2017, the trust allocated a caseworker to support the prison administrative team with complaints management processes. However, records showed that of 153 complaints that had been closed by the LCFT Hearing Feedback team since 1 April 2017, only 76 (50%) had been responded to within local timescales. Of the 43 complaints, which we reviewed, 26 (60%) had no written reply and 19 (45%) received a response later than the 25 working days stated in the trust's policy. Written replies for two complaints took six months, two took four months and four took three months. There was comprehensive monitoring of the complaint system, but insufficient evidence that the monitoring was being used to improve response times, or that learning from complaints was used to improve service delivery and shared with staff.

Are services well-led?

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

Our findings

We did not inspect the well-led key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued following the inspection in July 2016 and concerns raised to CQC by whistle blowers.

At our last inspection in July 2016, we found that the trust had made improvements to leadership and patient care and that local healthcare management had the capability and capacity to manage the service appropriately. However, we also found a range of concerns specifically in relation to how the prison regime impacted upon patient care and the responsiveness of the service.

Whistleblowing concerns reported to CQC suggested that leadership and governance may be ineffective. The allegations included:

- Staff and manager misconduct.
- Lack of action in response to incident reports.
- Insufficient prison staff to support healthcare delivery.
- Poor management support for staff.
- One occasion when insufficient healthcare staff were deployed at night.
- Partnership working arrangements with prison staffing impacting detrimentally on patient care.

Vision and strategy

During this inspection, we saw evidence that LCFT had a strategy to improve the service and the local management team had further ideas and suggestions for ongoing improvement.

Governance Arrangements

There was a strong governance culture within LCFT and a range of trust policies available to staff. However, we saw evidence that some trust wide policies were not effectively embedded at HMP Liverpool. These included:

- Staff supervision
- Hearing Feedback and complaints management
- Medicines management
- Continuous learning from audits
- Complaints

We saw that all of the 451 incidents which had been reported in the six months prior to this inspection had been reviewed by LCFT managers, actions were taken and where possible lessons learned had been listed. Lessons learned were reviewed by the management team, though it was not clear how lessons learned were systematically shared with relevant staff.

We were also informed of a number of on-going investigations into staff conduct.

We looked in detail at staffing rotas for specific dates in August and September 2017. The evidence provided was contradictory and the trust was unable to provide an accurate account of staff on duty. Records did not support accurate monitoring of staffing levels or provide assurance of adequate staffing.

The healthcare team within the prison had introduced a range of monitoring systems to help address the complexities of providing health and social care within the prison environment. This included recording an audit trail for appointment slip delivery to patients that identified the responsible prison staff.

Systems to escalate and monitor occasions when insufficient prison staff were present to enable inpatients to access basic activities like access to fresh air and showers, were not sufficiently effective. The escalation process for this was not always followed by healthcare staff. Staff were also required to submit a report via the trust incident reporting procedure but did not always do so. Trust incident reporting records showed eight occasions in the six months preceding our inspection where this was reported, staff told us this happened more frequently. This meant that prison management did not have the opportunity to take action at the time of each incident and were not aware of how frequently such incidents occurred.

There was a risk register in place for the prison location, the version shared with the inspection team prior to the inspection did not adequately reflect all the issues affecting care. However, during the factual accuracy process, additional evidence on the risk register was provided by the trust which demonstrated that risks around long-term conditions and overnight observations of patients on detoxification regimes were being monitored and mitigated where possible. The one area which was not reflected in the risk register was staff morale and culture, yet this had led to the cultural values assessment in August 2017.

Are services well-led?

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

Leadership and Culture

During this inspection we saw a team working exceptionally hard to care for patients, in difficult circumstances. However, the healthcare team did not always feel supported by the wider trust. Healthcare services within HMP Liverpool were impacted upon by two wider trust issues. The location of the prison, in Merseyside, meant that many LCFT community services were unable to provide services outside of Lancashire. Recent trust restructuring had caused prison healthcare staff to feel more isolated from the wider trust. These issues had affected the delivery of community equivalent pathways such as national screening programmes, which were now in place after many months of work by local clinical staff.

Staff gave us an example of how they did not feel well supported by the wider trust in the way which the trust had informed them of the decision to withdraw from providing healthcare services at HMP Liverpool from 31 March 2018. This had been done by letter in August 2017 and no meetings or discussions with staff had taken place to further support staff.

We saw evidence that LCFT had made significant efforts to recruit to fill staff vacancies and a number of successful candidates were awaiting security clearance at the time of the inspection. The trust had reviewed the staffing model twice since 2015 and introduced changes which led to improvements; for example in recruiting six pharmacy technicians for medication administration. However, the local management team told us that the new integrated structure around mental health and substance misuse had not worked as effectively as planned, and required review.

Staffing vacancies and sickness absence within the clinical and managerial teams and lack of supervision impacted on patient care, reducing available appointments and placing staff who were on duty each day under constant pressure which affected staff morale.

Despite evidence that prison management and local healthcare management met regularly to discuss issues affecting patient care, prison issues including staff shortages continued to impact on healthcare delivery. These issues were outside of the control of LCFT. Healthcare staff had implemented some monitoring and recording arrangements but these were not always followed. These concerns will be reported in more detail in the joint inspection report.

Seeking and acting on feedback from patients, the public and staff

Patient feedback systems, with the exception of the inpatient forum were not established and patient feedback did not inform service delivery.

Minutes from an inpatient forum meeting in March 2017 evidenced that healthcare management had discussed with patients the possibility of facilitating film or book reviews and relaxation sessions, though these were not yet happening. One improvement to the inpatient regime had been the introduction of a rehabilitation gymnasium in the healthcare building. However, patients only had access to this facility when a physical education officer (prison staff) was able to attend to supervise the activity.

Staff feedback systems were in place, but there was no clarity on how this would inform service development. The trust had commissioned a cultural values assessment with staff, which was carried out in August 2017. A range of issues were highlighted by this which included staff wishing to focus on on-going development of working practices and knowledge, with employee engagement noted as the top desired value. There was no corresponding action plan and it was not clear how this would be used to improve the services.

Continuous improvement

Healthcare staff were highly focused on delivering good quality patient care during the inspection.

We found:

- Notes were kept from daily team meetings so that information could be shared with all staff.
- Commitment and flexibility of the staff team to consistently support patients in their care.
- Effective staffing model changes to improve patient care.
- Additional case worker support allocated to the complaints process to support prison administrative staff. However there remained insufficient management capacity to investigate and respond to complaints in a timely way in line with trust policy.
- The introduction of the long-term condition nurse specialist.

Are services well-led?

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

- The use of the Quality and Outcomes Framework (QOF) (a voluntary annual reward and incentive programme for primary care in England, to support good practice in the management of long-term conditions) to improve care for, and monitoring of, patients with long-term conditions.
- Effective implementation of national screening and sexual health pathways.
- The development of the Talking Therapies service.
- Improved care planning and patient case notes in the electronic patient record system.
- An improved reception screening process which ensured that most significant health and social care needs were identified when men arrived into the prison.
- Clear monitoring and prioritisation of patients who required external hospital treatment and evidence of partnership working with prison management to improve patient outcomes.
- Ongoing development of end of life pathways for men with palliative care needs.

It was not clear what support measures the trust would put into place during the period that the it remained responsible for the prison healthcare contract to ensure that the service could continue to be developed to improve patient care. Local mangers expressed concerns about their ability to review and improve services before the trust's contract to provide services at HMP Liverpool ceased.

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
Diagnostic and screening procedures Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The system for receiving and acting on complaints was not operated effectively. How the regulation was not being met: • Complaints were not investigated effectively and in a timely way with appropriate action taken to address patients' complaints. • Complainants were not kept informed about the status of their complaints and investigations in accordance with trust policy.

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not operate effective systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. How the regulation was not being met: • Complaints monitoring did not actively inform service improvement and learning was not shared with staff to improve patient care. • Appropriate recording, monitoring and learning from prescribing errors was not embedded to improve prescribing safety and patient care. • There was no system for engagement with patients in the main prison and no patient survey to inform service delivery and improvement.

This section is primarily information for the provider

Requirement notices

- Audit systems for the dental service did not inform service improvement. The quality of dental x-rays was not monitored and learning from a dental record audit carried out in November 2016 was not shared with staff to improve patient care
- Monitoring of staffing levels was not sufficiently robust. Staffing rotas for the nights of 31 August to 2 September 2017 did not accurately reflect which staff had worked.
- Staff supervision and performance review records were not accurate or up to date.

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure appropriate support and supervision was in place to enable staff to carry out the duties they were employed to perform.** **How the regulation was not being met:** • Clinical staff did not receive appropriate managerial and clinical supervision in line with the trust policy. • Staff did not receive regular appraisals of their performance. • Healthcare support workers conducted reviews of patients with substance misuse needs without appropriate clinical support.