HMP Liverpool

Quality Report

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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.

Summary of this inspection

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Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

- There was an effective system in place for reporting and recording significant events.
- Lessons learned were shared to make sure action was taken to improve patient safety
- Risks to patients were assessed and well managed.
- Equipment was maintained and in good working order and staff were trained in its use.
- The registered provider had reviewed and implemented changes to their prescribing, ordering, administration and in-possession procedures. This had reduced the number of missed doses due to a lack of stock or if the person did not attend for medicines to be administered.

Are services effective?

We did not inspect the effective domain in full at this focussed inspection. We inspected only those aspects mentioned in the requirement notices issued on 2 November 2015.

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Care planning and the management of risks for patients who attended primary healthcare services required development.
- The care and treatment for patients with complex health needs and lifelong conditions was insufficient and underdeveloped.
- Patients with mild to moderate depressive/anxiety type illness did not receive a timely service.

Are services caring?

We did not inspect the caring domain in full at this focussed inspection. We inspected only those aspects mentioned in the requirement notices issued on 2 November 2015.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

  Care planning and the involvement of patients who attended primary health care services in their care and treatment were not in place. However, care planning and involvement were sufficiently developed for patients accommodated on the inpatient unit.

Summary of findings

Are services responsive to people's needs?

- Patients could wait up to three weeks for a routine GP appointment, however a number of on the day urgent appointment were available. The number of GP appointments where a patient failed to attend remained high.
- An effective complaints and concerns system was in operation.

Are services well-led?

- The registered provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients at HMP Liverpool.
- There was a clear leadership structure and most staff felt supported by management.
- Clinical and internal audits were undertaken and used to monitor quality and to make improvements to service delivery.
- There were good arrangements for identifying, recording and managing risks, and implementing mitigating actions.
- There was a focus on continuous learning and improvement across healthcare services within HMP Liverpool.
- Staff told us there was an open culture across the health care team and they had the opportunity to raise issues at team meetings. Most staff reported that the 'culture and atmosphere' across healthcare had improved.

Summary of findings

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- The registered provider must do all that is reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients.
- Care planning and the management of risks for patients who attend primary healthcare services and the integrated mental have team must be developed.
- The care, treatment, review of patients with complex health needs and lifelong conditions must be developed.
- Patients with mild to moderate depressive / anxiety type illness must have equivalent access to mental health support services.
- Patients must have access to routine GP appointments equivalent to waiting times within the community.
- Patients must have access to regular medication reviews.

Action the service SHOULD take to improve

The areas where the provider should make improvements:

- Ensue appropriate arrangements are in place for monitoring and auditing the management and use of controlled drugs by the Controlled Drugs Accountable Officer.

HMP Liverpool

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a CQC pharmacist specialist and a health inspector from Her Majesty's Inspectorate of Prisons.

Background to HMP Liverpool

HMP Liverpool is a local prison for remand and sentenced adult males in the Merseyside area. It can hold up to 1400 adult men.

Lancashire Care NHS Foundation Trust provides primary physical and mental healthcare, secondary mental healthcare and substance misuse 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.

CQC inspected healthcare services at the prison in partnership with her Majesty's Inspectorate of Prisons in May 2015 and found the trust was in breach of the regulations. We asked the trust to make improvements and we followed up on their progress during a focused inspection on the 25 & 26 July 2016.

Why we carried out this inspection

We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

In May 2015 we undertook a joint inspection of health services at HMP Liverpool with Her Majesty's Inspectorate of Prisons under a memorandum of understanding agreement. We found areas of concern about the service provided by Lancashire Care NHS Foundation Trust and issued four requirement notices on the 2 November 2015. We followed up the requirement notices during this focused inspection. We also widened the remit of the inspection to include the well led domain in order to have a clear understanding of governance arrangements and how risks were being managed.

The joint inspection report with HMI Prison can be found at:

www.justiceinspectorates.gov.uk/hmiprisons/inspections

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the NHS England commissioner and registered provider to share with us other information, which we reviewed as part of the inspection.

We were on site for two days and during the inspection we looked at provider documents and spoke with healthcare staff, staff and patients.

To get to the heart of patients' experiences of care and treatment, we asked the following 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

Learning and improvement from safety incidents

- There was an effective system in place for reporting and recording significant events and all staff were aware of the system and how to report. We observed that incidents were reported and a register of reported events was kept to which all staff had access to and could input.
- There was a positive reporting culture across health care at the prison. Staff voiced concerns on a regular basis via the Datix System and to their line managers. Staff understood reporting processes and escalated incidents and events appropriately. This included reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. We reviewed the frequency, severity and type of medicines incidents logged since our previous inspection. Data indicated a reduction in the severity and frequency of incidents and a significant reduction in the top two categories of "failure to administer medicines" and "medicine omitted".
- We reviewed incident reports and minutes of meetings where events were discussed. We saw evidence that lessons were learned and shared and action was taken to improve safety across the health care team. Staff had the opportunity to discuss and learn from significant events during the 'Harm Free Meetings' held weekly. The aim of the meetings was to provide assurance to the 'service line governance group,' that arrangements for managing, safeguarding and improving the quality and safety of patient-centred care was in place and lessons were learned. Learning was also shared with staff at daily team hand overs.
- The registered provider had a risk register where all reported incidents were recorded with actions to address identified risks. This was used to monitor the effectiveness of lessons learned and mitigating actions were in place to provide assurances that improvements were being made, risks reduced and trends identified.

Medicines management

- At a previous inspection we had concerns about the unsafe management of medicines including the administration and supply of medicines. During this inspection we found that patients received their medicines safely; when they needed them. Medicines administration times were four times a day seven days a week. We saw each patient present their identification card and confirm their name prior to receiving any medicines. Medicines were administered to each patient from the treatment room and patients were provided with appropriate drinks to aid them to take medicines.
- The e-Prescribing and Medicines Administration (ePMA) record had been correctly completed.
- Medicines were stored securely in the dispensary and treatment rooms located on the wings. Temperature records were reviewed for all areas where medicines were stored. These provided assurance that most had remained with the recommended temperature range or appropriate action had been taken. However, the dispensary records for July 16 indicated that the dispensary room temperature in one area had exceeded the maximum recommended for storing medicines. When we raised this with staff they told us that whilst air conditioning had been fitted it had not been commissioned and they would follow this up.
- Processes were in place to check medicines were within their expiry date and suitable for use. However, we saw four insulin pens that were being stored at room temperature which lacked a revised expiry date following removal from a refrigerator. Expired and unwanted medicines were disposed of in line with waste regulations.
- The trust held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. We identified inconsistences in the auditing of controlled drugs.
- Nurses used Patient Group Directions (PGDs) to administer vaccines that had been produced in line with legal requirements and national guidance. PGDs are written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of people for a specific condition. Homely remedies

(medicines which the public can buy to treat minor illnesses like headaches and colds) were available for registered healthcare professionals to administer within the prison.

- Within the reception process a GP reviewed a patient's medicines, initiated appropriate prescriptions and completed an in-possession risk assessment. In-possession enables patients to keep their medicines with them and take them when prescribed.
- Medicines were obtained by the trust from either a registered pharmacy or a medicines wholesaler as appropriate. Hand written prescriptions had been recently introduced for urgent prescriptions and were stored securely. A prescription tracking systems was being developed in line with national guidance, but had not been implemented at the time of the inspection. Systems and processes were in place for the review; reauthorisation and re-supply of in possession and individually dispensed medicines.

Equipment

- On a previous inspection we found that equipment used for transferring patients in the inpatient unit was not maintained and staff were not trained to use it safely. We found that patients located in the inpatient unit did not have access to equipment, such as alarms, should they need to alert staff.
- On this inspection we found hoisting equipment was maintained and in good working order and each patient had their own personal sling. Staff were fully trained in manual handling and the use of hoisting equipment.

Staffing and recruitment

- The healthcare team had a number of vacancies across the inpatient unit, the primary care team and the integrated mental health team.There was a rolling recruitment programme in place with plans to appoint new staff and to transfer staff from within the trust to the prison to ensure that the healthcare team were sufficiently staffed to meet the needs of patients.In the meantime the trust ensured that vacancies were covered by bank staff and regular agency staff who had experience of working in prisons.
- The trust had a 'HMP Liverpool inpatient unit improvement plan', which included objectives to address staffing levels and appropriate skills mix.

Monitoring risks to patients

- On a previous inspection we had concerns that risk assessments for patients who were unable to mobilise independently on the inpatient unit were not routinely completed.During this inspection we found that risks to patients were assessed and well managed and were routinely completed on all patients admitted to the inpatient unit. Patients had a range of risk assessments depending on need, for example, bed rail assessments and falls risk assessments.Risk assessments needed to be developed for patients who accessed primary health care services and services from the integrated mental health team.
- Daily handover meetings' took place for the primary health care team, the integrated mental health team and twice daily on the inpatient unit. Patients' care and treatment needs were discussed at handover, along with identified risks.
- A daily situation report was produced and monitored weekly.It reported on bed availability within the inpatient unit, and the percentage of patients with social care needs who did not need to be in hospital.
- Arrangements were in place for planning and managing the number of staff and skill mix needed to meet patients' needs.There was a rota system in place for each team to ensure sufficient appropriate staff were on duty.

Arrangements to deal with emergencies and major incidents

- The trust had a business continuity plan, that would be implemented in the event of a major incident. This detailed actions that would be taken to protect patients and staff.
- Emergency medicines and equipment including oxygen were available in the prison and all healthcare staff knew of its location. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.
- The majority of staff had completed training in basic or intermediate life support as appropriate for their role and an on-going programme of life support training was scheduled.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- On a previous inspection we were concerned that patients on the inpatient unit were not having their care needs fully met. We observed that care plans were generic, did not fully address individual patients' needs and were not reviewed regularly. There was no evidence that patients had been involved in planning their care. During this inspection we reviewed inpatient assessments, care plans and risk assessments. We found assessments were completed in a timely manner, were of good quality and patients' needs were documented.
- Care planning for patients on the inpatient unit was well developed. Admission and discharge arrangements were in place and this ensured that patients' needs were assessed at the point of admission and discharge.
- Care planning and the management of risks for patients who attended primary healthcare services required development.
- We found that a number of patients with social care needs, who needed assistance with personal care, were accommodated in the inpatient unit due to a lack of suitable facilities across the prison. All prisoners were screened for social care needs on reception. Partnership working with Liverpool City Council was good. We were told that Liverpool City Council had contracted the trust to provide social care.
- Previously we had concerns about patient access to an initial health screen upon their reception into the prison. On this inspection we found the provider had reviewed the arrangements around initial health screening and this included an initial physical health screen and a mental health screen which was undertaken by a registered mental health nurse within 72 hours. Nursing staff actively followed up on all patients including all those who failed to attend.
- Arrangements were in place for a registered mental health nurse to all, Assessment, Care in Custody and Teamwork (ACCT) reviews daily. An ACCT document is the central source of information when dealing with prisoners who are deemed to be at risk of suicide or self-harm.

Management, monitoring and improving outcomes for people

- Medication reviews were not routinely happening. However patients that attended routine GP appointments had the opportunity to discuss and review their medicines and management of their condition.
- Clear mental health pathways were in place, based on a multi-disciplinary stepped care model, and were regularly monitored. A weekly 'allocations' meeting of mental health teams reviewed all new referrals and those patients giving cause for concern.
- However staffing shortages within the integrated mental health team impacted on patients. Patients in crisis and those on a care programme approach (CPA) were seen, but patients with mild to moderate depressive/anxiety type illness waited longer to receive a service.
- The care and treatment for patients with complex health needs and lifelong conditions was insufficient and underdeveloped.
- Patients with long term conditions, for example, diabetes and asthma were not sufficiently monitored. There were no patient recall systems in place for patients with long term conditions. Patients with complex health care needs did not routinely have a care plan in place.
- Staffing shortages within the primary care team meant that nurse led clinics did not happen regularly. A very recent initiative was the introduction of an asthma clinic. The trust had plans to schedule clinics for epilepsy, diabetes and heart failure.

Effective staffing

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The trust had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to, and made use of, e-learning training modules and in-house training.

Are services effective?

(for example, treatment is effective)

- A review of the integrated mental health team was underway and had identified training for staff in the application of the 'care plan approach',(CPA) was needed along with care planning and risk assessments for patients with complex mental health problems.

Coordinating patient care and information sharing

- Information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the electronic patient record system, known as SystmOne.
- Staff had access to assessments, care plans and risk assessments for patients on the inpatient unit. Though less information was available for patients who attended primary healthcare services.
- There was good evidence of information sharing and coordinating patient care particularly around social care needs assessments.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

- We observed members of staff were courteous towards patients and treated them with dignity and respect.

Care planning and involvement in decisions about care and treatment

- Patients on the inpatient unit told us that staff spoke with them and consulted them about the care and treatment they received.
- All patients on the unit had a named nurse.
- We saw that care plans on the inpatient unit were personalised and were reviewed on a regular basis. They focused on maintaining patient safety and actions to enable a safe discharge.
- Care planning and the involvement of patients who attended primary health care services in their care and treatment was not in place.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- On a previous inspection we were concerned that the inpatient unit did not provide for a therapeutic environment that supported patients' recovery and wellbeing. The inpatient unit remains part of the operational capacity of the prison and the environment is not the direct responsibility of the registered provider. However we noted during this focused inspection that the unit continued to offer a reduced therapeutic regime. We were told that gym staff had been redeployed and this reduced the opportunity for patients to attend the gym. Similarly education staff had been attending daily and this had also been withdrawn due to staffing shortages. There were plans to introduce a reading group in August 2016.
- Nursing staff were able to provide opportunities to provide direct one to one work with patients.
- The inpatient unit had communal areas both internally and externally which patients' could access.

Access to the service

- Previously we reported that waiting times for some services including the GP were too long and there were no systems in place to follow up patients who did not attend. During this inspection we found that patients could wait up to 3 weeks for a routine GP appointment. However patients with identified urgent needs were usually seen promptly. We found the prison regime sometimes impacted on a patient's ability to attend their appointment particularly if they were not unlocked or not escorted to healthcare. The number of appointments where the patient 'Did not attend' remained high.
- A recent initiative had been introduced to follow -up on patients who failed to attend an appointment with the GP and to assess if the appointment was still needed. It was too early to judge the success of this initiative.
- Despite nurse triage arrangements being in place this had not positively impacted on the waiting time or requests for appointments to see a GP.
- Patients 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.
- Previously we reported that admission and discharge policy for the inpatient unit. The policy specified that the beds within the inpatient unit remained part of HMP Liverpool's operational capacity. This meant that the Governor and other prison staff could instruct the admission of non-clinical admissions to the unit. When this happened partnership working between the trust and the prison occurred with the aim of maintaining staff and patient safety.

Listening and learning from concerns and complaints

- On a previous inspection we found that complaints were not managed effectively or in a confidential way. There was limited information available for patients about how to raise a concern and what their options were should they be dissatisfied with the outcome of the complaint investigation. On this inspection we found the provider was operating an effective complaints and concerns system. We saw that information was available to help patients understand the complaints system though patients on the inpatient unit had to request a complaints form which may prevent some patients for making a complaint.
- There were designated members of staff both clinical and non-clinical responsible for responding to patients' complaints. In recent weeks the trust had arranged for all complainants to receive a written response to their complaint. We found that responses were timely, appropriate and offered an apology and for the majority of occasions addressed all the complainants' issues.
- A complaint log was monitored and the trust had plans to periodically sample complaints to audit the quality of responses and to ensure that complaints were resolved to patients' satisfaction. Themes were discussed at management and governance meetings.

Are services well-led?

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

Our findings

Vision and strategy

- The registered provider had a clear vision to deliver high quality care and was focused on promoting good outcomes for patients who used healthcare services within HMP Liverpool.

Governance arrangements

- There was a clear staffing structure across health care services within the prison and that staff were aware of their own roles and responsibilities.
- Recruitment, staffing levels and skills mix were monitored.
- Clinical and internal audits were undertaken and used to monitor quality and to make improvements to service delivery.
- A new clinical forum, held bi-monthly, had replaced a previous GP clinical forum. The aim of which was to focus on clinical based issues and encourage greater attendance by a range of clinical partners.
- There were good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

- On the day of inspection the clinical lead, the service manager, and senior clinical staff demonstrated they had the experience, capacity and capability to provide health care services for the prison population at HMP Liverpool.
- There was a clear leadership structure in place and the majority of staff felt supported by management. Staff were involved in discussions about how to develop the service.
- Staff told us there was an open culture across the health care team and they had the opportunity to raise issues at team meetings. Most staff reported that the 'culture and atmosphere' across healthcare had improved since our last inspection.

Continuous improvement

- There was a focus on continuous learning and improvement across healthcare services within HMP Liverpool.
- The registered provider had a 'Long term conditions strategy', dated July 2016 that acknowledged and had begun to address this service gap. All long term conditions patients' had been identified and added to a long term conditions waiting list. It was envisaged that all patients would be seen before the end of August 2016.The strategy included nursing staff working closely with GPs to ensure that accurate read codes were used as part of the Quality and Outcomes Framework (QOF). Read codes
- The 'Long term conditions strategy' also included the appointment of a long term condition nurse in autumn 2016.
- 'Well man screening', was implemented in June 2016 which addressed the backlog of outstanding secondary health screens. This was completed during our inspection.
- The registered provider had a plan to implement a health promotion strategy that would support the long term conditions strategy by offering health awareness clinics, for example, stop smoking clinics and diabetes awareness. It was envisaged that this would be in place by September 2016.
- Social Care meetings were held monthly and were attended by the head of inpatients, alongside Liverpool City Council, senior representatives from the trust, including a safeguarding lead and the clinical lead for the prison.
- An inpatient improvement plan was in place which addressed key areas such as staffing, named nurses, care planning and admission and discharges processes.
- A review of the integrated mental health team and its pathways was underway, including how the team integrated with inpatients and substance misuse services across healthcare.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **How the regulation was not being met:** The care, treatment, review of and monitoring of patients with complex health needs and lifelong conditions was insufficient and under developed. Patients with mild to moderate depressive/anxiety type illness did not receive a timely service. Patients did not have good access to routine GP appointments equivalent to waiting times in the community. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. Care planning and the management of risks for patients who attended primary healthcare services and the integrated mental health team were under developed.

This section is primarily information for the provider

Requirement notices

Patients did not have access to regular medication reviews.

This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.