Her Majesty's Prison Whitemoor

Quality Report

Longhill Rd,
March
Cambridgeshire
PE15 0PR
Tel:
Website:

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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.

Contents

Overall summary

This inspection was an announced focused inspection carried out on 4 December 2017 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection between 20 and 23 March 2017. The March 2017 comprehensive inspection was carried out in partnership with Her Majesty's Inspectorate of Prisons (HMIP) in accordance with our published methodology.

Summary of findings

This report covers our findings in relation to those aspects detailed in the Requirement Notices dated 28 July 2017 and the joint HMIP/CQC report recommendations that related to healthcare delivery. We do not currently rate services provided in prisons..

Our key findings were as follows:

- There were positive relationships between trust staff, the prison and service commissioners, which were contributing to service improvements.
- Significant improvements had been made to the way medicines were managed that improved patient safety, patient experience and the effectiveness of medicines. There was good oversight and monitoring by a pharmacist.
- The safety of the dental service was monitored and risks were being addressed. The planned refurbishment of the dental suite had not commenced and there were concerns about the reliability of ageing equipment.
- Actions to improve services to patients with mild to moderate mental health needs were well advanced but not yet complete.
- Patients' general health was being more actively promoted and a joint wellbeing strategy was being developed with the prison.
- Trust staff were no longer providing personal care to prisoners. Proper formalised arrangements were in place to ensure prisoners' personal care needs were met.

  However, there were also areas of practice where the provider needs to make further improvements.

The provider should:

- Implement additional recommendations from the NHS England Pharmaceutical Adviser's report (September 2017) to ensure best practice in medicnes optimisation
- Continue to work proactively with the prison and NHS England commissioners to ensure that the planned dental suite refurbishment is completed as soon as possible.
- Complete the planned recruitment of nursing staff intendedto ensure that patients' needs are consistently met.

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 did not inspect the safe domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notices in July 2017 issued as a result of the inspection in March 2017 and the joint HMIP/CQC report recommendations that related to healthcare delivery.

We found that this registered location was providing safe care in accordance with the relevant regulations.

Improvements had been made that addressed some of our previous concerns about the safety of the dental service and medicines management. Refurbishment of the dental suite had not commenced but the provider had taken all reasonable action to progress this. Further joint working with the prison and NHS England commissioners was needed to promote patient safety and experience.

Are services effective?

We did not inspect the effective domain in full at this inspection. We inspected only those aspects detailed in the Requirement Notices in July 2017 issued as a result of the inspection in March 2017 and the joint HMIP/CQC report recommendations that related to healthcare delivery.

We found that this registered location was providing effective care in accordance with the relevant regulations.

The provider had taken appropriate action to address the previous breaches of regulations and joint report recommendations in relation to, the effectiveness of medicines, the provision of social care support, health promotion and mental health staffing levels.

There remained a need for further improvement to medicines management, health promotion and mental health staffing levels to ensure the effectiveness of the service.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

We did not inspect the responsive domain at this inspection.

Are services well-led?

We did not inspect the well-led domain at this inspection.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve
The provider should:

- Implement additional recommendations from the NHS England Pharmaceutical Adviser's report (September 2017) to ensure best practice in medicnes optimisation.
- Continue to work proactively with the prison and NHS England commissioners to ensure that the planned dental suite refurbishment is completed as soon as possible.
- Complete the planned recruitment of nursing staff intendedto ensure that patients' needs are consistently met.

Her Majesty's Prison Whitemoor

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was completed by a CQC health and justice inspector who was accompanied by a healthcare inspector from Her Majesty's Inspectorate of Prisons. The inspection team had access to remote specialist advice

Background to Her Majesty's Prison Whitemoor

Her Majesty's Prison Whitemoor is a high security dispersal prison that holds around 430 men, all serving long sentences for serious offences. Northamptonshire Healthcare NHS Foundation Trust provides a range of primary healthcare services to prisoners, comparable to those found in the wider community. This includes nursing, GP, mental health, substance misuse and pharmacy services. Dental services are subcontracted. The location is registered to provide the regulated activities: treatment of disease, disorder, or injury, diagnostic and screening procedures and surgical procedures.

CQC inspected this location with Her Majesty's Inspectorate of Prisons between the 20 and 23 March 2017. We found evidence that fundamental standards were not being met and two Requirement Notices were issued in relation to Regulation 12, Safe care and treatment and Regulation 15, Premises and equipment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked the trust to make improvements regarding these breaches. We checked these areas, and other relevant joint recommendations, as part of this focused inspection. We found that the provider had addressed the previous breaches of regulations identified that fell within their control and remit.

Why we carried out this inspection

CQC and Her Majesty's Inspectorate of Prisons (HMIP) undertake joint inspections under a memorandum of understanding. Further information on this and the joint methodology can be found by accessing the following website: http://www.cqc.org.uk/content/health-and-care-criminal-justice-system CQC inspect under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

We undertook a comprehensive inspection of Her Majesty's Prison Whitemoor between 20 and 23 March 2017. The joint inspection report following the inspection on March 2017 can be found by accessing the following website: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-whitemoor-2/

In March 2017 we found evidence that fundamental standards were not being met and two Requirement Notices were issued in relation to Regulation 12, Safe care and treatment and Regulation 15, Premises and equipment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked the trust to make improvements regarding these breaches.

Detailed findings

We undertook a follow up focused inspection of Her Majesty's Prison Whitemoor on 4 December 2017. This inspection was carried out to review in detail the actions taken by the provider to improve the quality of care and to confirm that Her Majesty's Prison Whitemoor was now meeting legal requirements. We also reviewed progress against the joint HMIP/CQC report recommendations that related to healthcare delivery.

How we carried out this inspection

During our visit we:

- Spoke with a range of prison and healthcare staff and spoke with patients who used the service.
- Observed how patients were being cared for in the close supervision centre and in the healthcare waiting room

We also reviewed a range of documents that showed how the service was being managed and how improvements were being made:

- Northamptonshire Healthcare NHS Foundation Trust's action plan from CQC/HMIP inspection in March 2017, updated 27 November 2017
- NHS England report from a pharmaceutical adviser's visit to HMP Whitemoor, 14 September 2017
- Performance management report, HMP Littlehey & HMP Whitemoor, October 2017
- Infection prevention and control audit for dental service, August 2017
- Infection prevention and control action plan for dental service, August 2017
- Medicines management meeting minutes
- Information about medicines audit information

Please note that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

At our previous inspection between 20 and 23 March 2017, we found that care and treatment was not always provided to patients in a way that protected their safety and welfare. Specifically, the safety of dental equipment, dental facilities and medicines management required improvement.

We saw evidence that the arrangements for the management of dental equipment and medicines management had significantly improved when we undertook a follow up inspection on 4 December 2017. However, the dental suite still required significant refurbishment to achieve best practice standards. Whilst the trust had contributed to the refurbishment plans, discussions between commissioners and the prison were ongoing at the time of this inspection.

Overview of safety systems and process

At our previous inspection between 20 and 23 March 2017, staff were unable to provide inspectors with sufficient evidence that dental equipment and facilities were safe. Dental services were subcontracted from another provider but the trust retained the overall responsibility for governance of these services. Essential certification was not available on site, nor was it provided following the inspection. The trust's action plan in response to our Requirement Notices, issued in July 2017, showed that all relevant certification was in place by June 2017. At the time of this focused inspection all assurance documents were in date.

In March 2017 the dental suite required substantial refurbishment to bring it up to infection control and best practice standards. The provider's action plan demonstrated that they had pursued this with the prison and commissioners on a regular basis and had contributed to discussions about the planned refurbishment. However, at this inspection we found that refurbishment had not commenced and that discussion remained ongoing between NHS England commissioners and the prison. This remained a concern but was outside the remit and control of the trust.

Pending refurbishment of the dental suite, in order to monitor and mitigate the ongoing risks, the dental provider submitted infection prevention and control audits to provide assurance of safety. An infection prevention and control action plan was in place. Dental equipment was being serviced and repaired as necessary. However, we were advised that some equipment, such as the dental chair was reaching the end of its life and may not be repairable in the future. This posed a risk to future service delivery. Monitoring data for October 2017 showed that the need for a recent repair to the dental chair had meant that some patients had waited 17 days for an urgent appointment, which was too long.

Dental staff had been invited to attend local clinical governance meetings, which provided an opportunity for all staff representatives to discuss identified risks.

Monitoring risks to patients

In March 2017 we found that medicines were not always safely administered and that patients were not always assessed regarding the risks associated with managing their own medicines. At this focused inspection it was evident that arrangements had been improved and there was effective oversight of how medicines were administered and risk assessed. A range of routine medicines audits were conducted by a pharmacist. Improvements were well embedded as confirmed by a report from NHS England in September 2017. Monthly meetings between a trust pharmacist and the lead GP had led to prescribing that more effectively supported risk management.

The completion and review of risk assessments to determine whether or not patients could safely manage their own medicines and hold them 'in possession' had been strengthened and staff were working to the trust's in possession policy. The percentage of patients receiving their medicines in possession had increased significantly without any associated rise in incidents. This had improved patients' experience and was more effectively promoting safety. The completion of in possession risk assessments was routinely monitored by a visiting pharmacist to ensure they were up to date.

Additional measures had been implemented by the pharmacy team to support safe administration of medicines on the prison's D wing, pending the creation of a dedicated clinical room. This was promoting patient safety, including ending the unnecessary practice of crushing medicines. Prescribing patterns had changed and more patients received their medicines in possession. The routine use of a monitored dosage system (MDS), which is a

storage device designed to simplify the administration of tablets or capsules, had been introduced. This reduced the risk of incorrect administration and improved medicines security.

In order to ensure safe medicines administration on the segregation unit there were plans in place to create a clinical room by April 2018, which trust staff had influenced. In the meantime, medicines were still being removed from their original dispensed containers and put into individually labelled, sealed pots in advance of the time of administration. This is generally considered to be a high risk activity; however, measures had been taken to minimise the risk of patients receiving the wrong medicines. Medicines were put into the pots within the healthcare department and transported securely to the segregation unit for individual administration during a period when prisoners were not circulating. The risks associated with these arrangements had been reviewed and approved by a NHS England pharmaceutical adviser.

Other actions were being taken to improve previously identified risks associated with medicines administration. Prescribers were actively considering the individual risk of enabling patients in segregation to hold their medicines in possession to reduce the requirement for nurses to administer. Inpatients now attended the pharmacy to receive their medicines, which removed the need to transport medicines to the inpatient unit. The pharmacist had provided medicines awareness training to prison staff to enable them to better support healthcare staff and patients.

Under pharmacist guidance the prescribing of night time medicines had significantly reduced to decrease the risks associated with administration and the need to wake patients to receive their medicines. All such prescribed medicines had been reviewed by a pharmacist and most night medicines were now prescribed in possession, or an alternative had been considered. At the time of this inspection night time medicines were being administered by nurses to only 17 patients, following risk assessment.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection between 20 and 23 March 2017, we found that medicines were not always managed to promote their effectiveness for patients and that staff did not always meet the needs of prisoners who required social care support. We also, in conjunction with Her Majesty's Inspectorate of Prisons, recommended improvements to the coordination of health promotion activity and mental health staffing levels.

These areas had significantly improved when we undertook a follow up inspection on 4 December 2017.

Management, monitoring and improving outcomes for people

At the time of our previous inspection medicines were not always prescribed for patients in accordance with prescribing guidance and in a way that ensured their effectiveness. In addition, records showed that patients' prescribed medicines were not regularly reviewed to check that they were still required and effective. Patients did not have access to a pharmacist for advice about their medicines.

Since March 2017 significant work had been undertaken by the pharmacist and GP prescriber to improve the management of medicines. All patients were now having their medicines reviewed at intervals and the completion of medicines reviews was being monitored. A monthly pharmacist clinic had commenced in May 2017, to which patients could be referred to discuss their medicines. The visiting pharmacist also reviewed any medicines-related complaints and met with complainants to resolve their concerns.

In March 2017 we found that some medicines were being prescribed at dosage intervals that contradicted national guidance, mainly because the constraints of the prison regime did not allow for medicines to be administered four times a day. Monthly audits and meetings between the pharmacist and GP had led to significant improvements. At this inspection evidence showed that this practice had changed and that medicines were now prescribed in a way that promoted their effectiveness. For example, tramadol (used to treat moderate to severe pain) was being prescribed in a long-acting form to reduce the need for more frequent doses. For the very few patients who still required their medicines more frequently, their prescriptions were being reviewed on an individual basis to achieve a therapeutic regime.

The monitoring of patients prescribed high-risk medicines that could potentially impact on their general health had been improved. At the time of this inspection less than 10 patients were requiring monitoring. Weekly nurse clinics had commenced in June 2017 that provided blood testing and other monitoring of patients who took high-risk medicines. A mental health worker had been trained to perform electro-cardiographs for patients receiving anti-psychotic medicines. These arrangements were audited quarterly by the pharmacist to ensure that patients were monitored in accordance with national guidance.

In March 2017 we found that there was no systematic approach to promoting the general health and wellbeing of patients across the prison. At this inspection we saw evidence that the trust had actively contributed to the whole prison approach through involvement in developing a wellbeing strategy and the delivery of nurse clinics. Nurse clinics had included a health promotion element from August 2017. There were clear plans in place to further improve health promotion through a draft joint strategy with the prison and accredited training for identified prisoner health champions.

Effective staffing

During our March 2017 inspection we had concerns about the level of mental health staff available to provide group therapies to patients. Since that inspection recruitment had been effective. A psychology assistant had commenced in post and two registered mental health nurses were awaiting the appropriate security clearance. Work was underway to introduce mindfulness sessions for patients, delivered by an independent facilitator. These improvements were expected to increase the staff's capacity to meet the needs of patients with mild to moderate mental health issues. Vacancies and staff absence meant that the mental health team was largely made up of agency staff; however, a universal referral system ensured that newly-referred patients were seen within two days

Coordinating patient care and information sharing

In March 2017 we found that trust staff were providing support to one prisoner who required support with his

Are services effective?

(for example, treatment is effective)

personal care needs. There was no clear agreement in place for this arrangement and the necessary care was provided inconsistently because nurses were often required to perform essential clinical duties. At this focused inspection we found that the arrangements for the provision of personal care to prisoners had been formalised and that trust staff were no longer delivering such care. Healthcare staff had been involved in developing the new arrangements and an agreement was now in place between the prison and the local authority to ensure that prisoners' social care needs could be met.

Are services caring?

Our findings

We did not inspect the caring domain at this inspection

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect the responsive domain at this inspection.

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 domain at this inspection.