City Health Care Partnership CIC - HMP Humber

Inspection report

1a Beck Road
Brough
Hull
East Yorkshire
HU15 1RB
Tel: 01482 347 620
www.chcpcic.org.uk

Date of inspection visit: 11 March 2019
Date of publication: 24/05/2019

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall summary

We carried out an announced focused inspection of healthcare services provided by City Health Care Partnership CIC (CHCP) at City Health Care Partnership CIC - HMP Humber (HMP Humber) on 11 March 2019.

Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in December 2017, we found that the quality of healthcare provided by at this location did not meet regulations. We issued one Requirement Notice in relation to Regulation 17, Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC also received concerns about patient care and whistle blowing allegations about health care services at HMP Humber between June 2018 and January 2019.

The purpose of this inspection was to determine if the healthcare services provided by CHCP were meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that patients were receiving safe care and treatment.

We do not currently rate services provided in prisons. At this focused inspection we found:

- Governance arrangements around medicines management had improved.
- The provider had recruited additional clinical staff.
- The range of support and interventions for patients with substance misuse and mental health needs had increased.
- Staff and patient engagement had improved.
- Staff felt well supported by the new management team but supervision was not fully embedded in line with CHCP policy.
- Governance arrangements were not fully effective at identifying and mitigating risks to patient care.
- Managers had built links with local community services and were clearly sighted on improving the offender health service to be equitable with community provision.

There are areas where the provider MUST make improvements:

- Ensure that monitoring and governance arrangements identify and address risks to patients.
- Ensure that patient clinical records are accurate and up to date to support appropriate decision making.
- Ensure that patients are given relevant information about their care and any incidents pertaining to their care.
- Ensure that staff supervision is provided in line with CHCP policy.

There are also areas where the provider SHOULD make improvements:

- Ensure that the movement of medicines within the prison is risk assessed to take account of prison activities.
- Continue to develop local audit processes to improve the quality of care.
- Ensure prescribing options for substance misuse treatment and harm minimisation support for patients released reflects national clinical guidance.

Our inspection team

The inspection was conducted by two CQC health and justice inspectors, one CQC hospitals inspector, one CQC pharmacist specialist as well as a GP CQC Specialist Professional Advisor.

Before this inspection we reviewed the action plan submitted by CHCP to demonstrate how they would achieve compliance and a range of documents submitted by CHCP. We also spoke with NHS England commissioners prior to the inspection. Evidence we reviewed included:

- Operating procedures, policies and audits relating to the use of medicines.
- Procedures for monitoring emergency equipment.
- Staffing arrangements including staff training and supervision.
- Minutes of team meetings and partnership meetings with prison management.
- Patient engagement meetings and results of friends and family test (FFT) surveys.
- Governance documentation demonstrating risk assessment and management.

During this inspection we spoke with a range of clinical and operational managers, staff from mental health, substance misuse and primary care services as well as administrative support staff. We also spoke with four patients.

Background to City Health Care Partnership CIC - HMP Humber

City Health Care Partnerships CIC – HMP Humber (HMP Humber) is a closed category C resettlement prison, located in Humberside which was formed in 2015 from the amalgamation of HMP Everthorpe and HMP The Wolds. The site is large and health care services are delivered in two zones within the prison. During our visit HMP Humber was holding around 930 male prisoners.

Health services at HMP Humber are commissioned by NHS England. The contract for the provision of healthcare services is held by City Health Care Partnerships CIC (CHCP). CHCP is registered with CQC to provide the regulated activities of Diagnostic and screening procedures, Personal care, Surgical procedures and Treatment of disease, disorder or injury.

Our last joint inspection with HMIP was in December 2017. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-humber-2/

This report covers our findings in relation to those aspects detailed in the Requirement Notices issued to CHCP in April 2018, areas where we made recommendations for improvement at the last inspection and the concerns which were raised to CQC between June 2018 and January 2019. We do not currently rate services provided in prisons.

Are services safe?

We did not inspect the safe key question in full at this inspection. We inspected only areas where we previously made further recommendations for improvements and concerns raised to CQC by whistle blowers. We found that the provider was providing safe care.

At our last inspection we found that arrangements to ensure safe management of medicines and emergency equipment were not being followed consistently and joint working between CHCP and the pharmacy provider was not always effective. Concerns alleged by the whistle blowers included staffing levels, staff competence in administering medicines and inadequate emergency response arrangements.

Risks to patients

A range of improvements had been introduced to reduce risks to patients.

The provider had increased staffing levels, particularly senior nurses, mental health and substance misuse staff, though some were still undergoing recruitment checking. This meant staffing levels were safer, allowing a better focus on identifying and reducing risks to patients.

Arrangements for responding to emergency incidents had been improved, including:

- An increase in the number of staff identified for responding to incidents. Staff informed us they felt more confident knowing they were supported in dealing with emergency situations. Many staff had now been trained to intermediate life support.
- Additional guidance and support was given to agency staff to improve timeliness of emergency responses.
- Emergency equipment was available and checked appropriately, though checklists were insufficiently detailed.

Improvements had been made to reduce risks to patients who had substance misuse treatment needs. There were regular prescribing reviews for patients prescribed opiate substitution treatment at key stages in their treatment. A new clinic had been introduced, which reviewed patients who had substance misuse needs and chronic pain. This ensured arrangements for prescribing and administration of medicines which have addictive qualities and can be high risk (for example leading to overdose) were safe, with patients offered physiotherapy to support pain management.

Nurses ensured that risk assessments were carried out for all newly arrived prisoners, to determine whether it was safe for them to hold medicines in possession. These risk assessments were reviewed regularly by nurses and prescribers, including when risks changed. For example, patients at risk of suicide or self-harm who were placed on an assessment, care in custody and teamwork document (ACCT, this is the prison process for supporting vulnerable prisoners who are at risk of self-harm or suicide) support plan by prison staff were reviewed to reduce their risk of overdose.

New processes had been put into place to improve infection prevention and control, with a new cleaner and regular checks of the environment. The environment and treatment rooms now met infection prevention and control requirements.

Information to deliver safe are and treatment

CHCP had recognised that not all information entered into electronic patient records by clinical staff was appropriately coded, which meant that important clinical information might not be easily accessible when clinical decisions were required. Managers had plans in place to introduce clinical codes into the templates which staff used. During the inspection, we also identified that external information from hospitals was not being appropriately coded into patient electronic clinical records. This meant that diagnoses and test results from external hospital visits could not be easily viewed and IT systems did not support staff in ensuring patient care was timely and appropriate. The provider acted on this during the inspection and additional training for administration staff was planned immediately along with a draft protocol to improve patient safety.

Managers had introduced a weekly 'virtual ward round' which ensured that all staff were aware of patients who had complex or high-risk health needs.

Discussions had been held with local mental health teams and plans were in place to give prison health staff access to community mental health records to improve continuity of care.

Safe and Appropriate use of medicines

Improvements since our last inspection meant that CHCP now had oversight of medicines storage, including managing the cold chain (ensuring the safety of medicines

and vaccines which can be affected by high or low temperatures). The provider had purchased monitoring equipment to continually monitor refrigerator temperatures. Staff conducted daily checks, with senior nurses conducting weekly audits to ensure these were effectively embedded.

Oversight of treatment rooms and medicines storage had improved.

- The service now employed a cleaner to ensure areas were clean and tidy.
- The provider had purchased medicines storage cupboards which were fit for purpose and ensured that medicines were stored safely and securely.
- Staff monitored emergency medicines and equipment daily.
- Medicines were now disposed of appropriately.

The provider was aware that administration of medicines, in particular opiate substitute treatment exerted significant pressure on staff due to the high numbers of patients in receipt of supervised daily medicines.

Over 250 patients each day were being administered methadone (a synthetic analgesic which is used to treat drug dependency). The provider was working in partnership with prison managers to introduce a third treatment room for administering methadone to reduce the potential risks at treatment times.

Despite plans in 2017 to pilot the introduction of buprenorphine (this is a synthetic analgesic used for treating drug dependency and used where methadone is not appropriate or contra indicated), no alternative to methadone was yet available.

The provider had acquired funding to introduce naloxone (naloxone is a medicine used to block the effects of opioids and reduce risk of overdose) for patients on release, and the plan to implement this was being finalised.

Where patients were in receipt of medicines which they kept in possession, medicines compliance checks were not being carried out appropriately. There was no embedded process to ensure these took place, or were recorded and followed up.

During our inspection, we observed medicines being transported in an unsafe manner. When we raised this as an avoidable risk the provider took steps to prevent this from happening again by liaising with prison staff.

The provider had introduced patient group directions (PGDs provide a legal framework to allow nurses to supply and administer specified medicines to patients without a prescription). These had been appropriately signed by the staff using them, but had not been authorised by managers. This was rectified during the inspection.

Track record on safety

At our inspection in December 2017, we found that medicines incidents and errors were not being appropriately reported, reviewed and learning was not being shared.

During this inspection, we saw evidence that medicines incidents were being reported and analysed. Recent themes which managers had shared with staff included dispensing errors and medicines storage issues.

We reviewed the incident reporting processes during this inspection and saw that there had been a significant increase in both the numbers of incidents and the range of staff reporting incidents. Between September 2018 and February 2019 there had been 120 incidents reported and investigated compared with 26 between July 2017 and December 2017.

Lessons Learned and improvements made

The provider had improved communication with pharmacy staff over learning from incidents and now all staff received updates at team meetings and by email.

Where managers identified learning needs from incident reviews they had acted promptly to address these. For example, agency staff had been asked to complete the CHCP's cold chain and PGD training and had kept records of this training.

Are services effective?

We did not inspect the effective key question in full at this inspection. We inspected areas where we previously made further recommendations for improvements and concerns raised to CQC by whistle blowers. We found that the provider was providing effective care.

At our last inspection we found that there were insufficient mental health and substance misuse interventions to meet patient needs due to staffing pressures in both teams and many patients did not have care plans in place. Patients also waited up to 12 weeks for routine dental appointments. Concerns alleged by the whistle blowers related to staff competence, training and support for staff, inadequate mental health and substance misuse care and treatment and clinics being regularly cancelled.

Effective needs assessment, care and treatment

During this inspection we found that there was a greater range of support and interventions available for patients with mental health and substance misuse needs.

- National Institute for Clinical Excellent and relevant clinical guidance were being used to develop patient pathways including a new learning disability pathway which supported patients with autism, attention deficit hyperactivity disorder (ADHD) and acquired brain injuries.
- The provider had recruited staff into the mental health and substance misuse teams and the numbers of patients on individual staff's caseloads were lower.
- The referral and assessment process into the mental health team was clearer and used nationally recognised assessments of anxiety and depression.
- A mental health nurse assessed all referrals promptly and prioritised patients with mental health needs based on risk.
- A range of self-help materials were provided to patients with mild to moderate mental health needs.
- A counsellor had been in post since January 2018 and a psychologist had been recruited.
- A range of group interventions were provided by the substance misuse team and one to one interventions and support was available for patients for whom group work was not appropriate. Groups included peer led support sessions, a 12-week structured programme and stress management.
- The psychiatrist was able to provide additional sessions if required and now attended a weekly multi-disciplinary meeting where patient care was discussed.
- Staff conducted appropriate assessments for each patient and there were personalised care plans in place.

The dentist had provided additional dental clinics to reduce waiting times and patients waited less than four weeks for routine dental appointments now.

The provider had also improved arrangements to support patients with physical health needs. Staff had attended additional training in long-term conditions and developed clear pathways in line with national guidance. This included nurses reviewing pathology results for example for blood tests. Nurses liaised with GPs where any results were unclear or required additional clinical oversight.

Monitoring care and treatment

Managers had introduced a range of monitoring and audits for many aspects of health services. New clinical leaders were in place and they were being supported by managers to develop monitoring processes further.

The provider had systems in place to monitor access to the service and identify when additional clinics were required. There was regular monitoring of clinic cancellations and access to external hospital appointments.

Effective staffing

The provider had reviewed the staffing structure and effectively recruited additional staff to improve patient care. A new staffing and clinical leadership structure had also been implemented.

A daily rota showed clearly which nurses were responsible for which duties, including emergency response, which was a shared responsibility. This reduced the necessity for staff to close medicines hatches at early treatment times, although the demand for health staff to respond to incidents remained high.

Staff received appropriate induction and mandatory training for their roles and were encouraged to undertake a range of development and training opportunities. Staff were positive about the opportunities and support they were offered to develop their knowledge and skills. New substance misuse staff had not yet attended an external accredited course but were booked to attend.

Are services effective?

Staff were positive about the support and supervision they received, though some said they had not had formal supervision for several months. Managers were working to embed a more effective supervision process.

Clinics were no longer regularly cancelled due to insufficient staff and patients could access the GP for routine appointments within three weeks despite the provision including three clinical sessions weekly only.

The provider was reviewing the GP arrangements and actively reducing the demand on GP appointments. For example, mental health nurses who were also non-medical prescribers had recently commenced clinics to review patients with mild to moderate mental health need who were prescribed medicines. They worked closely with the GPs and psychiatrist to ensure patients' treatment was effective.

Caseloads for both mental health and substance misuse staff had reduced.

Coordinating care and treatment

Management had ensured that effective communication and joint working between staff in the primary health, mental health and substance misuse teams was in place. This included daily briefings attended by all teams, weekly complex case and multi-disciplinary meetings and the virtual ward round.

There was also regular attendance at prison meetings and new arrangements to ensure that where prisoners were placed on an ACCT document, an appropriate member of health care staff attended reviews and worked effectively with prison staff.

There was good joint working between the substance misuse and mental health teams to support patients with dual diagnosis.

Interventions offered by the substance misuse team were also available to patients with mental health needs as well where appropriate.

Management were building up relationships with community partners, local GP practices, mental health and substance misuse teams and urgent care teams. Pathways were being drawn up to offer a more integrated and seamless service to patients from the Humberside area.

Helping patients to live healthier lives

The provider was actively developing the service, including supporting patients to make healthy lifestyle choices. This included:

- Annual health checks for patients with complex mental health needs and learning disabilities as well as NHS health checks for all patients over 35.
- Easy read booklets were available to help patients learn more about the support services available.
- A health promotion lead had commenced work within the substance misuse team to improve the harm minimisation work and build a wider range of health promotion information for patients.
- There was now a range of talking therapies available and access to person centred counselling to support patients.
- Several members of the mental health team were trained and had begun using eye movement desensitisation reprogramming (EMDR) techniques to support patients who had post-traumatic stress disorder.

Consent to care and treatment

Records we reviewed showed that staff clearly explained care options to patients. Staff documented patient consent in patient clinical records consistently.

Are services well-led?

We did not inspect the well-led key question in full at this inspection. We inspected aspects mentioned in the Requirement Notice issued to CHCP in April 2018, areas where we previously made further recommendations for improvements and concerns raised to CQC by whistle blowers.

At our last inspection we found that oversight of governance including medicines management required improvement and patient engagement to support service development was limited. Concerns alleged by the whistle blowers included staff competency, inappropriate staff management, complaints management and patient information security.

Leadership capacity and capability

CHCP had recruited a new head of healthcare, who worked closely with the operational manager for the service. Management had identified new clinical leads in the mental health, primary health and substance misuse teams.

Leaders demonstrated an awareness of the service risks and the work required to continually improve the service.

Vision and strategy

There had been recent discussions about the service vision and staff clearly understood this. Staff were clear about an integrated offender health strategy and making every contact count, including trying to reduce duplication and improve communication about patients. Staff and managers we spoke to demonstrated a commitment to person centred care throughout the service.

There was a comprehensive service delivery plan in place which was monitored regularly.

Culture

Staff told us there had been a real change in the culture of the service. They said they now felt very supported by managers, and were confident in raising concerns if they had them. Incident reporting included concerns about behaviour and values, and incidents were appropriately investigated.

Following a patient death, managers invited staff to join the prison debrief in addition to CHCP support. We were told staff felt more confident working with prison colleagues now.

We saw evidence of open discussions with patients over the risks associated with using illicit substances.

Staff told us they felt valued and listened to.

Governance arrangements

Managers told us they were working with CHCP human resources and governance colleagues to develop and embed a range of governance arrangements. New governance meetings were held every three months. Not all monitoring arrangements were yet effective. Managers promptly began to address several concerns during the inspection.

For example, whilst arrangements to monitor that locally reported complaints were responded to in a timely way had been implemented effectively, there was no quality assurance process in place and the complaints responses we reviewed were poor. Staff dealing with complaints had not had sufficient training in managing complaints and responses did not include advice on how a patient could escalate their complaint if they were dissatisfied with the response.

Incident reporting and monitoring had improved since the inspection in December 2017.

Monitoring of staff training was effective, and included agency staff, yet monitoring of staff supervision and support was insufficiently embedded. Whilst staff told us they felt well supported, some advised they had not had formal supervision for over six months. The monitoring system which CHCP shared with us was insufficiently developed.

Governance arrangements around medicines management had improved and there was better joint working between CHCP and their sub-contracted pharmacy provider.

The provider was in the process of updating the Duty of candour policy, but assurance around Duty of candour was insufficient at the time of our inspection. Records showed that the provider had not been open with one patient about an incident which had been reported and investigated.

Managing risks, issues and performance

The provider had identified several risks to the service and had corresponding action plans in place. However, not all risks had been identified.

Are services well-led?

The provider had introduced a new staffing structure and recruited successfully to fill vacancies to improve patient safety and care. Some posts remained filled by regular agency staff and the provider was working with prison management to reduce vetting delays to staff commencing in post.

The provider had identified risks with the current GP provision of three weekly sessions of two and a half hours and planned to recruit a lead GP and review the working arrangements.

A range of monitoring had been embedded and local clinical leads told us of areas where they intended to make further improvements.

Appropriate and accurate information

The provider was aware that there were data quality issues with the templates in the patient electronic clinical record not being coded appropriately. Managers advised us that they had requested support from data quality leads in the community to address this. During the inspection we identified that relevant clinical information from incoming correspondence such as hospital discharge letters was not being coded into patient records. This impacted on monitoring arrangements and reduced the effectiveness of reporting through the clinical system.

When we raised the associated risks with managers they took prompt action. A clinical coding training session was set up for the next morning for administrative staff and coding protocols were drafted after the inspection.

Engaging with patients, the public, staff and external partners

A patient forum had been introduced and patient views were taken into consideration to develop and improve the service. Patients were invited to complete friends and family test surveys (FFT). In the last six months, 123 surveys had been returned, 83 per cent of these they were likely, or extremely likely, to recommend the service.

Staff described how they were involved in developing new clinical pathways, and were being given support to increase their knowledge and skills to improve the service. For example, staff who had taken on lead roles in supporting patients with long-term conditions and improving care pathways had attended relevant training.

Clinical leaders were now encouraged to attend prison meetings, and staff described improving relationships with prison colleagues.

CHCP had made organisational changes to bring prison healthcare within a wider service, which included community urgent care, general practices and learning disability teams. Managers and clinical leaders now worked more closely with community colleagues and we saw evidence of these relationships improving patient care within the prison.

Continuous improvement and innovation

Managers and staff described how the service was being improved consistently and evidence demonstrated the impact of the new leadership team in place. Managers described a range of innovative projects with community partners such the plan to bring in the data quality lead for GP practices to help develop the data quality within patient records.

There were ongoing discussions with local urgent care centres and plans to support staff to work in community settings to improve their knowledge and skills.

Mental health staff had worked closely with the community learning disability team to develop the prison pathway, to ensure it covered an equivalent range of care to the community service.

Work was taking place with local partners and GP practices to review pathways to and from the community including release from prison and maximise the opportunity of patients' time in prison to address their health inequalities.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to monitor and improve the quality and safety of the service were not fully effective. These included: Clinical coding was not being used effectively. Clinical information from secondary care was not being coded into patient records to ensure its availability for decision-making. Patient group directions had been signed by staff but not by authorising managers. Responses to local concerns were not comprehensive or conciliatory in tone. There was no quality assurance process in place for local complaints and concerns. Staff supervision was not happening in line with organisational policy requirements and monitoring was insufficiently embedded. There was no system in place for compliance checks where patients were issued medicines in possession. The application of the duty of candour policy did not effectively support a culture of openness and transparency. A patient was not informed of an incident relating to their care.