City Health Care Partnership CIC - HMP Hull

Inspection 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.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Overall summary

We carried out an announced focused follow up inspection of healthcare services provided by City Health Care Partnership CIC (CHCP) at City Health Care Partnership CIC – HMP Hull (HMP Hull) to check that the provider had made the necessary improvements. Following our last inspection in November and December 2020 we found the governance systems operated by CHCP at this location required improvement. We issued a Requirement Notice in relation to Regulation 17, Good Governance.

The purpose of the 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 prisoners were receiving safe care and treatment. This inspection was carried out alongside Her Majesty's Inspectorate of Prisons (HMIP) during a joint inspection of all services provided by CHCP at HMP Hull.

We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering how we carried out this inspection. We therefore undertook some of the inspection processes remotely to minimise infection risks due to the coronavirus pandemic.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection we found:

- Patients with long-term conditions were not always being cared for safely in line with national guidance, including the management of their medicines.
- A system had been implemented to schedule long-term conditions reviews in advance.
- There was ineffective triage of patients' applications for a healthcare appointment and urgent need wasn't always identified and acted upon.
- Patients requiring wound care and social care support did not always receive this in line with their care plan.
- There were significant backlogs of patients requiring a mental health assessment or awaiting allocation to a staff member's caseload.
- Mental health patients did not receive physical health checks in a timely way.
- Care plans relating to long-term conditions and mental health were not personalised in consultation with patients.
- Staffing pressures continued due to the impact of the pandemic. The provider had recruited to many roles, but several vacancies remained.
- While staff felt supported and had access to peer support, there was little formal management supervision taking place and such meetings were not always recorded.
- Governance systems and processes had been developed further since our previous inspection but remained insufficiently embedded to assess, monitor and improve the quality and safety of patient care.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Consult with patients to determine the care and treatment provided is suitable and reflects their specific needs and preferences and document this in the patient's personalised care record, in relation to long-term conditions and mental health needs.
- Implement a system which ensures that patients requesting a healthcare appointment are clinically triaged, allocated to the correct waiting list and prioritised based on clinical need.
- Ensure that service users requiring a mental health assessment and ongoing mental health care and treatment (including associated physical health checks) receive this and are prioritised based on their clinical need.

Overall summary

- Devise and fully implement an effective governance system to provide oversight of risks to the safety of service users and ensure that action is taken to mitigate such risks. This must include an effective audit programme which identifies areas of risk and identifies measurable actions which are fully implemented and reviewed.
- Ensure that staff receive supervision in line with the provider's own supervision policy and that such supervision meetings are recorded, and any actions are implemented.
- Patients requiring ongoing wound care and treatment should receive this in line with their care plan.
- Patients who have a social care package in place should receive the care they require as set out in their care plan.

The areas where the provider **should** make improvements are:

- Continue with their recruitment to fill remaining vacant positions.
- Continue to engage with community specialist teams in order to improve the care of patients with long-term conditions.

Our inspection team

Our inspection team was led by a CQC health and justice inspector supported by a GP specialist professional advisor (GP SPA). This inspection was carried out alongside two Health and Social Care Inspectors from HMIP who were carrying out a full inspection of HMP Hull.

How we carried out this inspection

Alongside our HMIP colleagues, we jointly conducted a range of interviews with staff and accessed patients' clinical records remotely and on site between 19 and 29 July 2021. We sampled 20 records of patients with various long-term conditions as well as records of patients with other physical and mental health needs. We reviewed the waiting lists for various primary care services, mental health and substance misuse services.

Before this inspection we reviewed a range of information that we held about the service including the provider's action plans in response to our previous inspection. Following the announcement of the inspection, HMIP requested additional information from CHCP which we jointly reviewed.

During the inspection we spoke with:

- Three nurses across the primary care and mental health team
- Two additional members of the mental health team
- Two healthcare assistants
- One GP
- Members of the Drug and Alcohol Recovery Team
- The Head of Healthcare and three service leads
- The Medical Director
- The General Manager
- The pharmacist and members of the pharmacy team.

We also spoke with NHS England commissioners and CHCP senior leaders.

The provider shared a range of evidence with us. Documents we reviewed included:

- Audits including those relating to diabetes care, record keeping and infection control
- Quality assurance and governance meetings records
- CHCP transformation plans and meeting minutes
- Root cause analyses and learning from incidents
- Local policies, procedures and standard operating procedures
- Staff rotas and the staff training matrix
- Staff newsletters
- Service risk register and action plan trackers
- Notes from staff meetings
- Figures relating to appointments not attended.

Background to City Health Care Partnership CIC - HMP Hull

HMP Hull is a local male adult Category B prison serving the East Yorkshire area. The prison is in the city of Hull and, at the time of the inspection, accommodated 965 prisoners. The prison is operated by Her Majesty's Prison and Probation Service.

Health services at HMP Hull are commissioned by NHS England. The contract for the provision of healthcare services is held by City Health Care Partnership 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 at HMP Hull.

Our previous comprehensive inspection was conducted jointly with Her Majesty's Inspectorate of Prisons (HMIP) in April 2018 and published on the HMIP website on 7 August 2018. We found breaches of Regulation 9, person-centred care and Regulation 17, good governance. The report from this inspection can be found on the HMIP website at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-hull-1/

CQC conducted a focused inspection in March 2019 of aspects of service provision under Regulation 9, person centred care and Regulation 17, good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Previous breaches of Regulations had been addressed during this inspection. The report from this inspection can be found on our website at:

https://api.cqc.org.uk/public/v1/reports/2bdd3753-59c3-4028-863f-4ae2339b5e06?20190401235021.

CQC conducted a focused inspection in November and December 2020 in response to a serious incident and we found a breach of Regulation 17, good governance. The report from this inspection can be found on our website at:

https://api.cqc.org.uk/public/v1/reports/ba0938a3-7a9c-4f88-9af2-2fac4722db08?20210302080037

Inspected but not rated

Are services safe?

Risks to patients

At our last inspection we found that there wasn't an effective system in place for ensuring Medicines and Healthcare Regulatory Agency (MHRA) and patient safety alerts were received and actioned. We also found there was a lack of follow up when clinical observations or test results were outside of normal expected limits.

During this inspection we found that there was a system for receiving MHRA and patient safety alerts and they were disseminated to staff in a timely way. However, there were continued issues with the follow up of patients with diabetes whose clinical observations or test results were outside of normal expected limits. We found examples in patient records where action had not been taken; for example, in supporting patients with diabetes to achieve their target HbA1C (blood sugar) levels to reduce the risk of developing complications. We also saw that some patients were not prescribed the correct medication in line with NICE guidance.

Our remote sample of patient records demonstrated that clinical risks to patients were not always being identified and action was not always being taken to reduce these risks. For example, investigations for potential renal complications or further investigations into a reduced blood count had not been carried out in two cases which placed patients at risk of serious harm from complications related to their conditions. We raised our concerns with the provider during the inspection and they took action to ensure that these, and other patients received the appropriate tests and follow up.

Within the sample of records reviewed for patients identified as having Chronic Obstructive Pulmonary Disease (COPD), a group of lung conditions that cause breathing difficulties, we identified that patients were not consistently being assessed for risk in line with national guidance.

Patients submitted a paper application to request a healthcare appointment and these were collected and reviewed daily. However, the process to triage applications and allocate these to the correct healthcare professional was not effective and more urgent issues not always identified. There were 150 patients on the combined GP and Pharmacist waiting list with the longest wait being five and a half weeks. We brought this to the attention of the provider during the inspection who confirmed that many of those patients should not have been on this waiting list and they were reallocated. This meant that those patients waited longer than necessary to access the service they required which put them at increased risk. One patient had complained of breathing difficulties and had been waiting for a GP appointment for five weeks. We saw that staff had attended an incident a week prior to the inspection where this patient had been found unresponsive. Whilst the patient was seen in the immediate aftermath of this incident, they had not been prioritised to see the GP to investigate this further.

Waiting lists for other healthcare professionals were not being monitored effectively and it was not clear in many cases what the reason was for the patient being on a waiting list or how urgent their need was. For example, there were 32 patients on the electrocardiogram (ECG) waiting list with the longest wait being five weeks. However, there was little information to indicate the reasons for the ECG being requested or the level of urgency. The provider took action when this issue was raised and arranged for all of the ECGs to be carried out. Patients with identified mental health needs and medicines did not always receive physical health checks, such as ECGs and blood tests, as required.

Risks to patients with mental ill-health were not always identified and addressed. Staffing vacancies combined with the level of demand for mental health services meant that patients did not receive care and treatment in a timely way which put them at increased risk. There was a lack of oversight of mental health assessments and caseloads due to insufficient leadership capacity which meant that risks to patients were not always identified or acted upon. There were 79 patients awaiting a primary mental health assessment with the longest wait being five weeks. Although patients received a brief

mental health screen soon after their arrival at the prison, this was not a full assessment and meant that any risk to these patients would not be fully understood. We were told that patients were seen based on the length of time they had been waiting rather than by clinical needs which meant there was a risk that patients with more urgent needs may not be prioritised.

An additional 50 patients were awaiting allocation to the caseload of mental health staff and those patients who were already on a caseload did not always receive interventions in a timely way. Staff told us they felt their caseloads were unmanageable. The provider acknowledged the issues with the provision of mental health services and took actions to bring in additional staff resource to begin to address the backlogs, which also included the provision of additional psychiatry sessions at weekends.

Appropriate and safe use of medicines

At our last inspection we found that patients who were prescribed high risk medicines were not always appropriately monitored and there wasn't always timely review of medicines following any abnormal readings.

The provider took action to ensure that patients' medicines were reviewed following the last inspection and we saw evidence in patient records of action being taken to review and amend prescribed medicines where required. However, we also saw evidence where some patients with known abnormal readings were not followed up appropriately to ensure their medicines were prescribed and monitored safely.

Our sample of patient records identified that patients who were prescribed high risk medicines were not always being appropriately monitored to ensure they were not adversely affected by the medicines, placing them at potential clinical risk. For example, patients who were prescribed anti-coagulants (medicines to prevent blood clots) were not always reviewed to monitor the effects of the medicine.

Lessons learned and improvements made

CHCP had a quality and clinical governance team who worked with local leaders and provided support to embed improvements. We reviewed minutes of quality meetings which clearly demonstrated understanding of improvements required following incidents, patients' complaints and feedback.

There had been some improvements in the care of patients with long-term conditions following our previous inspection. For example, the introduction of a recall system for annual reviews and the reintroduction of clinics by a diabetic specialist nurse. However, not all such improvements were fully embedded, and we found there continued to be issues with the care of some patients with a long-term condition.

The continued impact of the COVID pandemic on the prison and staff group had limited the provider's ability to further embed improvements. The provider ensured that core services, such as medicines administration and reception screening, were prioritised during periods of staff shortages. This limited the opportunities the provider had to embed improvements.

Lessons were not always learned from investigations into the deaths in custody that had occurred since the inspection in 2018. We saw some recommendations were repeated in subsequent investigations, meaning the required improvements had not been made. For example, recommendations relating to the care of patients with long-term conditions had not all been fully actioned and embedded.

Inspected but not rated

Are services effective?

Effective needs assessment, care and treatment

At our last inspection we found that the pathway for diabetic patient care had not been established due to the challenges posed by the pandemic. We saw there had been some progress made in establishing this pathway and that patients who required a diabetes review had either received this since the previous inspection or there was a review scheduled. The reintroduction of clinics by the diabetes specialist nurse was positive and helped to relieve some pressure on GP clinic capacity. The provider was working with their teams in community services to bring in additional expertise to help manage patients with long-term conditions. However, we found there continued to be issues with the management of patients with long-term conditions. Follow up actions were not always taken when readings were outside of the expected normal range and patients were not always prescribed the correct medicines and medicines were not always monitored as required.

There wasn't an effective system to help ensure patients with a severe mental illness received a physical health check in line with NICE guidance. This meant there was an increased risk of those patients developing avoidable physical health complications. Where the mental health team had requested that their patients received an ECG and blood test, these had not always been scheduled or carried out. We raised this issue with the provider during the inspection and they took action to ensure that those patients awaiting such tests received them.

Patients who required regular wound care did not always receive this care and treatment in line with their care plan. Records we reviewed showed that patients had not been seen or had their wound dressings changed at the set frequency which put them at risk of further deterioration or infection.

Ten patients were in receipt of a social care package, which CHCP were responsible for providing. We saw from patient records that this care was not always provided which meant that patients were at risk of not being supported to maintain their personal care. There wasn't an effective system to monitor what daily tasks had been completed, including social care, and those that remained outstanding. Following the inspection, the provider told us they had introduced a system for staff to check with each other what tasks remained outstanding and to ensure that these were allocated.

CHCP had continued working with a provider of clinical templates (used in electronic patient record systems to ensure care is carried out in accordance with national guidance) and had uploaded a batch of care plan templates to patient records several months before this inspection. The care plans we viewed were in relation to various long-term conditions and mental health. We saw that the majority of care plans were still based on the generic template and had not been personalised in consultation with patients. This meant patients were at risk of receiving care that was not appropriate or did not meet their needs.

Monitoring care and treatment

At our previous inspection we found that audits were not always carried out in a timely way and that audits did not always lead to improvement in patient care.

A diabetes audit had been carried out in October 2020, before our previous inspection. This had identified a number of issues with diabetes care, many of which had not been actioned. At this inspection we saw some of those actions had been carried out such as detailing information about blood sugar monitoring and the setting of annual reviews. However, other actions had not been taken such as the personalising of diabetes care plans and ensuring action was taken when

patients' readings were outside of the expected normal range. The provider's audit schedule stated this audit should be repeated every six months; however, we were not provided with evidence that this had taken place. This meant the monitoring of care and treatment was not effective because there had been no check that audit actions were being properly implemented.

Effective staffing

The service had staffing vacancies across the primary care and mental health teams but was continuing with recruitment campaigns in order to fill these vacancies. During our inspection managers confirmed several Advanced Nurse Practitioner and Healthcare Assistant posts had been recruited to. It had proven challenging to recruit into other roles and CHCP had adopted more innovative strategies, such as linking with a local university and offering developmental positions.

The impact of the pandemic had affected staffing levels across the service and sickness absence and self-isolation had meant there were occasions when the service was operating below the planned staffing levels. This meant mental health and substance misuse staff were sometimes asked to cover core primary care duties, such as medicines administration. Whilst staff understood why this was necessary, it had resulted in some frustration they were not able to focus on their own caseloads. Efforts were made by managers to fill gaps in the rota through the use of regular bank and agency staff.

CHCP had identified the need to increase staff skills and training and a transformation plan had been agreed to develop nurses who had worked within the prison environment for several years to become more aligned with community practice nursing and clinical skills. There had been work carried out with some of CHCP's community teams to develop the skills of staff, such as linking in with the community diabetes specialist nurse and tissue viability service. However, this work had been hampered by the restrictions imposed during the pandemic and the need to focus on delivery of core services for patients.

Staff had completed the majority of training considered to be mandatory for their role. While we saw that some gaps remained, actions had been taken to book staff on the required training. We also saw notices were displayed encouraging staff to complete their training. It had been more challenging for staff to use their training and skills to develop into lead roles, such as the care of older prisoners or respiratory conditions. This was due to staffing challenges and work pressures created by the pandemic.

At our previous inspection we saw supervision of staff had not been embedded into the service and at this inspection we found that this was still the case. The majority of staff told us they felt supported by their manager and colleagues, but that there had been little formal supervision taking place. We asked for evidence of supervision meetings taking place and were told there was no central record to confirm which staff had received supervision and when meetings had taken place. We were also told that some supervision meetings were more informal and not always recorded. Staff did have access to group supervision and peer support if required. Following our previous inspection, the provider had put in place additional support for staff identified as requiring this.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

The Head of Healthcare demonstrated they had recognised where improvements were required, and they had the capability to implement the changes required. However, their capacity was limited by staffing challenges and the need to prioritise core services for patients. The Head of Healthcare and Primary Care Lead sometimes had to provide clinical care due to staffing shortfalls, meaning that they could not fully focus on more strategic work. The Mental Health lead split their time between two prisons which meant they were not always available to provide support and oversight of the mental health team.

A general manager had been working regularly in the prison to provide additional support to the local managers and to oversee the implementation of required changes and improvements. Whilst senior leaders understood the work that was required, the limited capacity and continued staffing challenges meant it was difficult to fully embed new governance systems and oversight.

Following this inspection, the provider confirmed that they had brought in additional support from another of CHCP's locations to support the mental health team in addressing their workload. Additional positions had been created to provide further resilience to the team, such as the creation of a data quality role which would support with work on the clinical system (SystmOne).

Culture

The provider and Head of Healthcare had continued to manage some cultural issues within the staff team and promote a more open and forward-thinking way of working. Staff were positive about this work and clearly displayed and spoke about the vision and values of CHCP. Despite the challenging circumstances of working during the pandemic, staff had tried to maintain a positive and patient focused outlook.

Governance arrangements

At our previous inspection we found that CHCP had not established effective systems and processes to help ensure good governance in accordance with the fundamental standards of care. At this inspection we found there was a governance structure in place which had been further adapted following our previous inspection. However, risks identified in the previous inspection and further risks identified by CHCP were not always acted upon in a timely way.

Action plans that were linked to the results of audits did not always contain timebound or measurable actions and accountability for implementing each action was not clear. For example, a diabetes audit had been carried out which identified many of the issues that we found during this inspection, which meant that the required actions had not been embedded into practice. CHCP had devised a schedule of audits which set a timescale for the frequency that each audit should be carried out. However, we saw that audits were not repeated within the set timescale which meant there was limited opportunity to provide assurance that improvements were being made.

There was insufficient clinical oversight and review of various waiting lists for primary care and mental health services. This meant that patients were not always prioritised for appointments and, in some cases, had been placed onto an incorrect waiting list. For example, during the inspection we saw there were 150 patients on the combined GP and pharmacist waiting list with the longest wait being five and a half weeks. However, we were told that, upon review many of these patients could have been seen by other healthcare staff.

Inspected but not rated

Are services well-led?

There were large numbers of patients on various mental health waiting lists and there appeared to be little oversight or management of risks to patients' safety. We saw several examples where patients had requested mental health support, but this had not been provided. There were also many patients waiting for an initial mental health assessment or allocation to a caseload. Due to staffing challenges and a lack of oversight of waiting lists these patients had not received all of the required interventions.

Following the inspection, the provider instigated additional processes to provide internal assurance relating to the oversight and review of waiting lists. Additional staffing resource was brought in to help with a review of patients on the various mental health waiting lists and to provide assurance that patients presenting with more severe risks were prioritised.

Managing risks, issues and performance

CHCP was aware of the risks to the quality of the service provision and maintained a risk register. Some actions had been taken to try to bring about improvements following our previous inspection, such as additional support from a general manager and implementing an audit schedule. However, the continued impact of the pandemic and the staffing pressures that this created meant that it had been difficult to make the required progress in fully addressing risks. There wasn't sufficient capacity within the leadership team to ensure that risks were managed because managers were also having to provide clinical cover on the rota as well as working in another prison.

The provider took action after the inspection to bring in additional managerial support so that staff were then able to concentrate on their core work.

Continuous improvement and innovation

Our remote samples of patient clinical records identified a range of risks relating to long-term conditions management which we bought to the attention of the provider prior to our site visit. We asked the provider to take action to ensure that these patients received the appropriate care, treatment and follow up. During our previous inspection we raised a similar range of issues relating to long-term conditions management. CHCP provided assurances that lessons had been learned from this and felt that improvements had been made. However, we found that similar issues persisted which showed that improvements had not been embedded.

The provider has agreed to provide regular action plan updates to NHS England commissioners and CQC following this inspection.

This section is primarily information for the provider

Enforcement actions

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users did not reflect their preferences because the provider had not carried out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. The provider had not designed care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Enforcement action we took: We imposed conditions on the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way to service users because risks to the health and safety of service users were not always assessed and all reasonably practicable steps had not been taken to mitigate risks. Enforcement action we took: We imposed conditions on the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The systems to assess, monitor and improve the quality and safety of the services provided were not operated effectively. The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users were not operated effectively.

Enforcement action we took:

We imposed conditions on the provider.