WDP HMP Woodhill

Quality Report

WDP HMP Woodhill
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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

Detailed findings from this inspection

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 focussed inspection.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve patient safety.
- Risks to patients were assessed and well managed.
- There was sufficient staffing to ensure that patients were seen promptly and regularly.

Are services effective?

We did not inspect the effective domain in full at this focussed inspection.

- Staff completed appropriate assessments of patients health care and substance misuse.
- Care planning and the management of risks for patients was embedded within the service and central to the way in which staff worked with patients.
- Staff were knowledgeable and skilled to deliver safe effective care.
- Compliance with mandatory and other training was effectively monitored.
- Appropriate patient records were maintained.
- The way in which staff worked with other health care professionals in response to patients with complex health, needed further development.

Are services caring?

We did not inspect the caring domain in full at this focussed inspection.

- 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 accessed services was well developed .
- Patients had good opportunity to provide feedback on their view of the service provided.
- Staff were respectful and behaved in a non-judgemental way to patients.

Summary of findings

Are services responsive to people's needs?

We did not inspect the responsive domain in full at this focussed inspection.

- Patients had good access to the service, through regular appointments and relaxed informal arrangements.
- The service was available to patients 7 days a week and 24 hour nursing care was provided to patients located on the stabilisation unit.
- An effective complaints and concerns system was in operation.
- A coordinated response to patients health care needs required ongoing development.

Are services well-led?

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

- The registered provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and 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, issues and implementing mitigating actions.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve
The provider should:

- Further develop the way in which staff work with other health care professionals in response to patients with complex health needs.

WDP HMP Woodhill

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC health and justice inspector, accompanied by a second health and justice inspector. The team had access to remote specialist advice throughout the inspection.

Background to WDP HMP Woodhill

HMP Woodhill is a Category A male prison, located in Milton Keynes, and can accommodate up to 819 prisoners. The prison holds remand and sentenced prisoners aged 18 and above. In addition, Woodhill is one of the eight national high security prisons, holding Category A prisoners, some in the "Closed Supervision Centre". Westminster Drug Project (WDP) provides substance misuse services to prisoners with drug and alcohol problems detained at HMP Woodhill. The location, WDP HMP Woodhill is registered to provide the regulated activity of, treatment of disease, disorder or injury. WDP is a registered drug and alcohol charity who work with individuals, families and communities who are affected by substance misuse including, prison-based services. WDP provides an integrated clinical and psychosocial drug and alcohol services. The WDP team within the HMP Woodhill promotes a recovery focused way of helping prisoners overcome their dependency and to break the cycle of crime.

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. During our inspection we followed up on some recommended areas for improvement as identified by HMI Prisons during their announced inspection of the HMP Woodhill in September 2015.

We also inspected in direct response to concerns raised by the large number of deaths at the prison and concerns expressed in investigation reports following the deaths of prisons by the Prisons and Probation Ombudsman.

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a range of information which we reviewed as part of the inspection. We spoke with staff, commissioners and sampled a range of records.

We were on site for three days and during the inspection we looked at provider documents and patient records, spoke with healthcare staff, prison staff and people who used the service.

To get to the heart of patients' experiences of care and treatment on this inspection we asked the following questions:

- Is it safe?
- Is it effective?

Detailed findings

- Is it caring?
- Is it responsive?
- Is it well-led?

Are services safe?

Our findings

Learning and improvement from safety incidents

- WDP had an effective system in place for reporting and recording significant events and all staff were aware of the system and how to report.
- There was a positive reporting culture within the WDP team. Staff could voice concerns and raise incidents via an electronic system (Datix) and to their line managers. Staff understood reporting processes and escalated incidents and events appropriately.
- There had been a significant number of deaths at HMP Woodhill and where the deceased had been known to the WDP, it was team practice that a post death review was held within 72 hours and immediate actions identified and put in place when required. This was followed up by a detailed investigation report, completed within 28 days.
- Staff had the opportunity to discuss and learn from significant events during weekly team meetings, at one to one managerial supervision meetings and at daily hand over meetings. These meetings provided opportunities for lessons learned to be considered and relevant information was disseminated to the whole staff group.

Staffing and recruitment

- The team was fully staffed and were able to meet the needs of patients who engaged with the service.
- Arrangements were in place for planning and managing a number of staff and skills mix needed to meet patients' needs.

Monitoring risks to patients –

- WDP had their own risk register, where all reported incidents were recorded with actions to address identified risks. Incidents were logged, reviewed promptly and updated as necessary. All staff had access to the risk register and could add a new risk or update details on known risks.
- We found that risks to patients were assessed and well managed by WDP staff. Risk assessments for patients who used and engaged with the service were routinely completed and we saw evidence that risk assessments were reviewed and updated to reflect changes in patient need.
- Daily lunchtime team meetings took place and all members of the team attended. Information of concern and safeguarding concerns were shared during the meeting. Individual patients identified as being at risk were discussed along with planned interventions, including their clinical management and treatment. Referrals and awaiting the outcome of requested mental health assessments were discussed as was those prisoners who were on constant watch. The daily meeting also provided an opportunity to review incidents in treatment areas, out patients and security concerns.
- WDP held a safeguarding register for all prisoners known to the service who were thought to be vulnerable or at risk. All staff within WDP could identify and refer prisoners to the team safeguarding register. WDP shared their concerns of specific prisoners with operational wing based staff, with safer custody staff and with other health care partners that operated within the prison.
- A proportion of patients known to WDP were subject to an 'Assessment, Care in Custody and Teamwork', document (ACCT). ACCT is a process within the prison system that helps to identify and care for prisoners at risk of suicide or self-harm, through a care planning and review process. Regular ACCT reviews were held on all identified vulnerable prisoners and all professionals involved in the care and treatment of a prisoner, including health care services and substance misuse services were expected to attend such reviews to assess and monitor the care and treatment needs of a prisoner. It was the practice that WDP would attend all ACCT reviews on the stabilisation wing, but were not always able to attend ACCT reviews for prisoners located on wings across the prison.
- At the time of our inspection all prisoners undergoing an alcohol detoxification programme were located on the stabilisation unit. WDP nursing staff provided 24 hour nursing care to the stabilisation unit. This enabled staff to undertake nightly observations of patients in

detoxification and/or withdrawal. (The primary health care provider was responsible for overseeing the administration needs of substance misuse patients located on wings across the prison.)

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- Prisoners with identified alcohol or drug use at reception had access to a GP and a first night prescriber, until they could be seen by a WDP member of staff when prescribing responsibilities would be transferred.
- After having been assessed on the first night centre patients with drug or alcohol needs could be located on the stabilisation unit or located on other wings across the prison. The decision of where to locate a prisoner was made by operational prison staff in discussion with WDP s. Senior staff within WDP told us they felt that operational prison staff fully understood the importance and seriousness of prisoners undergoing detoxification being located on the stabilisation unit in order for night time observations to be completed.
- We reviewed patient care records, including health screens, care plans and risk assessments and found records were completed in a timely manner, were of good quality and patients' needs were documented. Care planning for patients know to WDP was well developed.

Management, monitoring and improving outcomes for people

- WDP staff were able to refer direct to primary health and mental health service via the electronic patient record system, if during the course of their work with a prisoner new or recurrent health care needs were identified. Prisoners requiring low level mental health interventions were managed by staff from WDP.
- Patients requiring follow up due to new or ongoing concerns could be raised at the lunch time team meeting. This provided further opportunity to assess the ongoing health needs of patients known to WDP.
- Joint working arrangements for patients with complex care needs had recently been reviewed. It had been identified that for patients who had a number of identified health care needs, including physical health, enduring mental health needs and substance misuse issues, there was a need for all service providers involved with the patient to periodically meet to discuss and review the patients care and treatment plans and risk assessments. WDP in partnership with their primary health and mental health colleagues had started to meet weekly to discuss such patients. This was a newly formalised arrangement and we did not have the opportunity to assess the effectiveness of these meetings at this inspection.

Effective staffing

- The skills mix of the staff team ensured that the needs of patients were met. The team included registered nurses, non – medical prescribers, recovery practitioners, pharmacy technicians, substance misuse general practitioners and a consultant psychiatrist specialist in addictions.
- Staff were trained and supported to perform their role. Staff were up to date with mandatory training, for example, safeguarding, advanced life support and life support and anaphylaxis training. Staff also had access to further specialist training, such as deprivation of liberty safeguards, mental health awareness and mental health capacity. Not all staff had completed training in mental health specific to their role, and staff had not completed training in suicide and self-harm.
- Staff were well supported and had access to formal clinical and managerial supervision. There were well embedded informal systems of supervision across the team and team members reported good work place rapport between colleagues.

Coordinating patient care and information sharing

- Information needed to plan and deliver care and treatment was available to all staff and accessible through the patient record system, known as SystmOne. The only exception to this was that records from sessions between recovery practitioners and patients engaged in psychosocial work were not recorded on SystmOne. WDP told us this was due to the large volume of notes that would need to be transcribed onto a patient's records and hand written records were kept.
- We found that where one or more health professionals were involved in a patient's care, particularly those with complex needs that required ongoing treatment, a multidisciplinary approach to meeting these patients' needs was lacking. However a recent initiative whereby trust staff attended a weekly substance misuse provider meetings to discuss patients with complex needs including associated mental ill health and/or substance

Are services effective?

(for example, treatment is effective)

misuse was a welcome development, as was the development of the interagency integrated clinical governance meeting, the first of which was held on 26 September 2016.

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.
- Staff gave an appropriate range of harm reduction information and advice.
- Patients we spoke with were positive about their contact and experience of the WDP service. Patients told us that WDP staff visited the stabilisation wing every day and patients could speak with staff and they found this helpful particularly if they were going through a difficult time with their treatment plan.
- Other patients described staff as 'approachable', 'supportive' and 'non-judgemental'. Patients told us they felt WDP staff listened to them.
- Patients' opinions of the treatment they received were largely positive, with some patients being satisfied with their detoxification plan and others who felt it was 'too quick.' One patient told us they were very happy with the release plan and support they received from WDP.

Care planning and involvement in decisions about care and treatment

- 'Service user' questionnaires were available and used to gather information on patients experience of the service. Patient responses were analysed and a report was produced quarterly and the results were used to inform service delivery.
- Monthly 'service user' forums were held to gather the views of patients. Including feedback on services that patients had engaged in, what they liked and what could be improved.
- A monthly patient newsletter, known as, 'Recovery Post', was produced in collaboration with patients who used the service. This provided information on activities and services available to support patients' wellbeing, including advice on the 12 steps programme and information on blood borne virus awareness.
- We saw that care plans were personalised and were reviewed on a regular basis and showed good evidence of patient involvement.
- Patient consent was sought, gained and recorded on patient care records.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- All prisoners with a history of substance misuse and/or current substance user status were seen by a WDP member of staff within 48 hours or sooner of being received into the prison and offered the opportunity for psychosocial intervention.
- The WDP service within HMP Woodhill promoted a recovery focused model and supported prisoners to overcome their dependency on substances. Staff worked jointly with patients, developing a care plan based on individual need and recovery aspirations.
- The team provided psychosocial support, including one to one, group work and clinical interventions.
- Clinical care in respect of the management and supervision of methadone was individualised with good support arrangements in place. Good arrangements were in place to support and maintain treatment for patients transferred to the prison who were on a supervised methadone programme.
- Patients on a reduction programme had the choice of also engaging in psychosocial interventions on a one to one basis or in groups. Group work included self-awareness and thinking patterns, drug awareness, triggers and coping strategies. Patients we spoke with spoke highly about the value in attending group work.
- WDP provided effective substitute prescribing and stabilisation services for opiate users, Benzodiazepine detoxification programmes and alcohol detoxification programmes including advice on harm minimisation. Measures were in place to provide symptomatic relief including first night, pending an assessment and review of alternative prescribing. Where there were concerns about a patient's mental health WDP liaised with the main primary health and mental health provider and arranged for a mental health assessment and or admission to the inpatients for a mental health assessment/treatment.
- Recent developments between WDP and primary health and mental health services to support patients with complex health needs required progression to ensure joint working arrangements were fully embedded.
- WDP staff actively followed up all patients that failed to attend for appointments and those who failed to attend for their medicines. Discussions were recorded on patient records and reviewed frequently; if this was a particular concern staff had the option of opening an ACCT for the patient.
- The WDP team developed links with local community drug and alcohol services for prisoners, at the point of arrival in prison and up to release, with the aim of securing a smooth and successful transition of the patient back into their community, and this included advice on housing.

Access to the service

- The WDP service was available to all prisoners identified at the point of an initial health screen with a history of drug and/or alcohol misuse or who were affected by drug and/or substance misuse.
- Prisoners could self-refer and any professional within the prison could refer prisoners to the service at any time during their stay.
- WDP provided 24 hour nursing care to prisoners located on the stabilisation unit and a clinical service between the hours of 7am and 9pm to other prisoners located across the prison. Recovery practitioners provided a service between the hours of 8am and 4pm.
- Prisoners with a history of, or were currently using drugs or alcohol, were seen by WDP staff within 48 hours or sooner of them being received into the prison.
- All prisoners who engaged in clinical and or psychosocial services had a named key worker. Prisoners on the stabilisation wing told us that staff were accessible and they could always see a WDP worker and those located on wings across the prison saw their WDP keyworker in the outpatient department for scheduled appointments.
- Patients who were actively engaged with psychosocial services were seen every four to six weeks by practitioners, more frequently if required. Patients who had completed their treatment plan could still access mutual aid or other interventions from the team. Others not directly engaged with the service could access support with release planning nearer to their release date. These patients were seen every 12 weeks for review.

Are services responsive to people's needs?

(for example, to feedback?)

- Information for prisoners about substance misuse services was advertised and promoted, particularly at the point when prisoners first arrived at the prison.

Listening and learning from concerns and complaints

- WDP operated an effective complaints and concerns system. Complaints were managed in confidential way. Information was available to patients about how to raise a concern and what their options were if they were dissatisfied with the outcome of the complaint investigation.
- The service manager for the team was responsible for responding to patients' complaints. We found that responses were timely, appropriate and offered an apology and addressed all the complainants' issues.
- Complaints were periodically audited by the Chief Executive Officer to ensure that complaints were resolved to patients' satisfaction. Emerging themes were discussed at 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 substance misuse services within HMP Woodhill.
- The overall vision of the service was to help patients recover from dependency, reduce offending and regain control of their lives. WDP staff were aware of the organisational vision and values.

Governance arrangements

- A new interagency integrated clinical governance meeting was a very recent initiative that was attended by WDP staff along with other registered healthcare providers within the prison, NHS England commissioners and the Governor. The first meeting was held on the 26 September 2016. The aim of the meeting was to review existing action plans that had been developed in response to reviews of deaths at the prison and develop one integrated action plan.
- WDP reported incidents via an electronic system (Datix) and all staff had access. Significant events were investigated and lessons learnt were disseminated and shared with all staff. Investigations into deaths in custody were shared with staff and other stakeholders within the prison. All of which were shared and reviewed by the clinical director and fed into the integrated local governance meeting.
- The WDP risk register was used to monitor the effectiveness of the service and mitigating actions were in place to provide assurances that improvements were being made, risks reduced and possible trends identified.
- WDP raised and monitored safeguarding concerns appropriately.
- There was a clear staffing structure across the WDP team and staff were aware of their own roles and responsibilities.
- Staffing levels and skills mix along with recruitment were monitored and there were a sufficient number of suitable staff employed to meet patient needs.
- There were good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Audits included risk assessments, death in custody folders, key worker contacts, ACCT information.
- Clinical and internal audits were undertaken and used to monitor quality and to make improvements to service delivery; these included complaints, care records and supervision records and frequency.

Leadership and culture

- Staff including the Chief Executive Officer and clinical lead, along with the service manager demonstrated they had the experience, capacity and capability to provide quality substance misuse services for the prison population at HMP Woodhill.
- There was a clear leadership structure in place and 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 substance misuse team and they had the opportunity to raise issues at team meetings.
- Staff were fully committed to working with and engaging with patients, many of whom they had known for a number of years and some who were frequently located within the prison due to their cyclical offending behaviours.

Continuous improvement

- There was a focus on continuous learning and improvement across the substance misuse service within HMP Woodhill.
- A review of care and treatment pathways for patients with 'dual diagnosis',(patients with drug and/or alcohol addiction and a severe and enduring mental health issue. e.g. Schizophrenia and Alcoholism) was underway, including how the team integrated with inpatients and primary mental health services within the prison.